

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13550

13548

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Odenton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 317 Nevada Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte J. Ahmuty				4. DATE OF DEATH Month Day Year October 6 19 66					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-1894		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home.		11. BIRTHPLACE (County & State, or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Pratt				14. MOTHER'S MAIDEN NAME Frances Moody					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Samuel Ahmuty, Sr.		Address Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic acidosis severe 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) H.S.C.U.D. - Probable, well DUE TO (c) Generalized arteriosclerosis -								INTERVAL BETWEEN ONSET AND DEATH 19 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-30-66 , 19 66 , to 10-6 , 19 66 , that (I) (we) last saw the deceased alive on 10-5 , 19 66 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE Felix Gruber				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/8/66			
22c. PHYSICIAN'S NAME (Type) Felix Gruber				22d. ADDRESS 113 Odenton Rd - Odenton					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/66		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d. LOCATION (City, town or county) (State) Odenton, Md.			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR OCT 11 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13549

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Bernie.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockview</u>	
c. LENGTH OF STAY IN lb <u>one day</u>		d. STREET ADDRESS <u>Rockview Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MME</u> Middle <u>A</u> Last <u>ALBAN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1907</u>
9. AGE (In years lost birthday) yrs. <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Wharton</u>		14. MOTHER'S MAIDEN NAME <u>Janie A. Schnaitman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mrs. Janie Hess - Bertha Rd., Rockview Beach</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>7824</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D.	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>10-15-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 19, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>George J. Gonce - 4001 Ritchie Hwy., Baltimore</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13331

13331

080-087

William H. Burton

William H. Burton

William H. Burton

George W. Jones - William H. Burton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
13552					13550										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
a. COUNTY Anne Arundel					a. STATE Md.										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millersville					b. COUNTY AA										
c. LENGTH OF STAY IN 1b 5 Weeks					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Manor Nursing Home					d. STREET ADDRESS 114 Fifth Ave. S. E.										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month			Day			Year			
First Allen			Middle Hampton			Last Allen			October			18, 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Nov. 1876		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Retired				11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William H. Allen						14. MOTHER'S MAIDEN NAME Martha Warfield									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Mrs. Ionia G. Allen, same as 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 177x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) carcinoma prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 5 days 3					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10-17-1966 to 10-18-1966 , that (I) (we) last saw the deceased alive on 10-14-1966 , and that death occurred at 1 PM , from the causes and on the date stated above.															
22a. SIGNATURE Charles R. MacDonald						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-20-66					
22c. PHYSICIAN'S NAME (Type) Charles R. MacDonald, M. D.						22d. ADDRESS 204 Grain Highway SW, Glen Burnie, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 21 Oct. 1966		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery			23d. LOCATION (City, town or county) (State) Anne Arundel Co., Md.							
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.						25a. REC'D BY REGISTRAR OCT 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL HOSPITAL</u>		d. STREET ADDRESS <u>103 Buckingham Dr</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>L</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-94</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>7</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES ADKINS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH OAKES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>223-508832</u>	
17. INFORMANT <u>MARY E. HANDY</u>		Address <u>103 BUCKINGHAM PL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Cancer of Mouth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Hemorrhagic Diverticulitis of Colon</u> (c) <u>144X</u> DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>9/18</u> , 19 <u>66</u> , to <u>10/10</u> , 19 <u>66</u> , that (2) we last saw the deceased alive on <u>10/10</u> , 19 <u>66</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul J. Chang, M.D.</u>		22b. DATE SIGNED <u>10/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul J. Chang, M.D.</u>		22d. ADDRESS <u>801 Chaimberg St. Glen Burnie</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/14/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Roselawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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Private Labels

7. no cash

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maryland House of Correction		d. STREET ADDRESS 2213 Whittier Avenue	
3. NAME OF DECEASED (Type or print) Wilbur L. Allen		4. DATE OF DEATH Month 10 Day 15 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1909
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 30 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Allen		14. MOTHER'S MAIDEN NAME Effie Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-5200	
17. INFORMANT Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), stating the underlying cause last. (c) 4201			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1. Pulmonary tuberculosis, activity undetermined 2. Cachexia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-14 1966 to 10-15 1966 , that (X) (we) last saw the deceased alive on 10-15 1966 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Jose M. Vosuico, M.D.		22b. DATE SIGNED 10-15-66	
22c. PHYSICIAN'S NAME (Type) Jose M. Vosuico, M.D.		22d. ADDRESS 117 Turf Valley Rd. Ellicott City	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/66	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town or county) (State) Brooklyn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles A. Price		25a. REC'D BY REGISTRAR OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEEMSCREEK - ANNAPOLIS		c. LENGTH OF STAY IN 1b 6 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRISTOL							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS OLE NEFF FARM		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle EDWINA Last ARMIGER				4. DATE OF DEATH Month 10 Day 5 Year 1966							
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1883		9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUSBAND		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ARTHUR E. HILSON				14. MOTHER'S MAIDEN NAME CATHERINE D. HERNHOLM							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 214-14-3191A		17. INFORMANT FAMILY		Address #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) KACHEXIA DUE TO (b) METASTATIC DISEASE DUE TO (c) CANCER OF RIGHT BREAST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170X						INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 years 16 years					
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE					
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
						20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1952 , 19__ to 2/5/66 , 19__, that (I) (we) saw the deceased alive on 9/21/66 19__, and that death occurred at 8:50 P.M. from causes and on the date stated above.											
22a. SIGNATURE L. BENEDICT				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/5/66					
22c. PHYSICIAN'S NAME (Type) L. BENEDICT				22d. ADDRESS Crownville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-7-66		23c. NAME OF CEMETERY OR CREMATORY ST. JAMES		23d. LOCATION (City or Town) (County) (State) LOTHIAN MD.					
24. FUNERAL DIRECTOR John M. L. & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE OCT 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13555					CERTIFICATE OF DEATH			13554		
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30-4					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital					d. STREET ADDRESS 1424 Barnes Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) #33437 Robert First Middle Last					4. DATE OF DEATH 10 23 19 66 Month Day Year					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 3/29/37		9. AGE (In years lost birthday) yrs. 29 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Lillian Armstead					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Recent Pulmonary Embolism 466 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Phlbothrombosis of Peri-Prostatic Venous Plexous (c) -----								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 4:00 p.m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----				
21. I certify that (I) (this hospital) attended the deceased from 9/30/66 , to 10/23, 1966 , that (I) (we) last saw the deceased alive on 10/23, 1966 , and that death occurred at 8:25M , from causes and on the date stated above.										
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/24/66		
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.					22d. ADDRESS Crownsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery			23d. LOCATION (City or Town) (County) (State) All County Md			
24. FUNERAL DIRECTOR Milton E. Elmer					ADDRESS 1129 N. Caroline St		25a. REC'D BY REGISTRAR DATE OCT 31 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

13524

CERTIFICATE OF DEATH

13524

Name		John William	
Sex		Male	
Age		23 years	
Date of Birth		1901	
Place of Birth		New York	
Occupation		Student	
Cause of Death		Diphtheria	
Date of Death		1924	
Place of Death		New York	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Medical Examiner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Funeral Home		[Signature]	
Signature of Cemetery		[Signature]	
Signature of Church		[Signature]	
Signature of Family		[Signature]	
Signature of Friends		[Signature]	
Signature of Neighbors		[Signature]	
Signature of Community		[Signature]	
Signature of State		[Signature]	
Signature of Nation		[Signature]	
Signature of World		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13556

CERTIFICATE OF DEATH

13555

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel		d. STREET ADDRESS 7806 Shellye Road	
3. NAME OF DECEASED (Type or print) First John Middle Gibson Last Atwell		4. DATE OF DEATH Month Oct. Day 17 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1907
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 02 Days 01 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - Auto.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Leesburg, Va.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Franklin T. Atwell		14. MOTHER'S MAIDEN NAME Capola French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-03-9894	
17. INFORMANT Louis F. Atwell, 311 Fifth Ave., N.Y.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/4, 1963 to 10/17, 1966 , that (I) (we) last saw the deceased alive on 10/10, 1966 , and that death occurred at 8:53 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman, M.D.		22b. DATE SIGNED 10/18/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 21 Oct., 1966	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Leesburg, Va.
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25. REC'D BY REGISTRAR DATE OCT 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14555

STATE OF NEW YORK

1885

No. 14555		State of New York	
In SENATE,		January 14, 1885.	
REPORT		OF THE	
COMMISSIONERS OF THE LAND OFFICE		IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, APRIL 11, 1884.	
ALBANY:		J. B. LIPPINCOTT & CO. PRINTERS, 1885.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

13557

CERTIFICATE OF DEATH

13556

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 515 Hornpoint Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Laurence A. BALDWIN Sr.		4. DATE OF DEATH Month Day Year October 1 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government -Retired		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ephraim F. Baldwin		14. MOTHER'S MAIDEN NAME Ellen Douglas Jamieson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 220-44-1895	
17. INFORMANT Laurence V. Baldwin		Address 311 Minorca Coral Gables, Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, primary (suspected) DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 48 hours --- years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, diabetes mellitus, congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Sept. 29 , 19 66 , to Oct. 1 , 19 66 that (I) (we) saw the deceased alive on Oct. 1 , 19 66 , and that death occurred at 8:15 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED 10/3/66	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS SouthRivMedCent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/1966	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR DATE OCT 5 1966	
ADDRESS 4905 York Rd. Balto., Md.		25b. REGISTRAR'S SIGNATURE gCharles Judge	

3533

12582

CERTIFICATE OF DEATH

13555

13557

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>660 Americana Drive, Bay Ridge Ave Apt. 25</u>	
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First Middle Last <u>BANON</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	9. AGE (In years last birthday) <u>85</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>PHILA, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>VALEARIO de CALRY</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN ABBOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ELIZABETH King</u>		18. ADDRESS <u>670 AMERICANA DR, ANNAPOLIS, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>UREMIA</u> DUE TO (c) <u>FRACTURED RIGHT HIP</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES</u> <u>SURGICAL WOUND INFECTION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL IN NURSING HOME</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>9-27</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>9-27</u> , 19 <u>66</u> , to <u>10-8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> , 19 <u>66</u> , and that death occurred at <u>3:15 AM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Leopold W. Lente</u>		22b. DATE SIGNED <u>10-9-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-12-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Saylor & Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 11 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2000

13224

13559

CERTIFICATE OF DEATH

13558

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1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Sylvan Shores	
3. NAME OF DECEASED (Type or print) First Daniel Middle (none) Last BARHAM Sr.		4. DATE OF DEATH Month October Day 7 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1903
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKERY DRIVER		10b. KIND OF BUSINESS OR INDUSTRY BAKERY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BENJAMIN BARHAM		14. MOTHER'S MAIDEN NAME CARRIE LEE WOODARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-09-0492	
17. INFORMANT Maddie BARHAM		Address Riva, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X Renal Cell Carcinoma DUE TO (b) Metastases - pulmonary DUE TO (c) NO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 6, 1966 , to Oct. 6, 1966 , that (I) (we) last saw the deceased alive on Oct. 6, 1966 , and that death occurred at 6:00 AM M, from causes and on the date stated above.			
22a. SIGNATURE Edwin Smith, Jr.		22b. DATE SIGNED 6:00 AM	
22c. PHYSICIAN'S NAME (Type) Edwin Smith, Jr.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Oct 10, 1966	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS, Md
24. FUNERAL DIRECTOR T.A. Hardesty		ADDRESS 12 Ridgeley Ave Annapolis, Md	
25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 18 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesville		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Evelyn Last BENNING		4. DATE OF DEATH Month October Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1896
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 hours year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Two previous thromboses & left hemiparesis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. , 19 61 , to Oct. 5 , 19 66 , that (I) (not) saw the deceased alive on Oct. 5 , 19 66 , and that death occurred at _____ M, from causes and on the date stated above.		22a. SIGNATURE Willard F. Smith M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D. 22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/66	
23c. NAME OF CEMETERY OR CREMATORY Quaker		23d. LOCATION (City or Town) (County) (State) Galesville A.A. Md.	
24. FUNERAL DIRECTOR Bernard O. Hardesty		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 Old Annapolis Blvd., Marley		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 301 Old Annapolis Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George W. Biddinger		4. DATE OF DEATH October 12, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 June 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self - employed		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Woodshoro, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Biddinger		14. MOTHER'S MAIDEN NAME Mary Holbrunner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mary Holbrunner		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from June 16, 1965 to Oct. 12, 1966 , that (I) (we) last saw the deceased alive on Sept. 23, 1966 , and that death occurred at 1031A M, from the causes and on the date stated above.			
22a. SIGNATURE Edmond Moushabek		22b. DATE SIGNED 	
22c. PHYSICIAN'S NAME (Type) Edmond Moushabek, M.D.		22d. ADDRESS 510 Marley Station Rd., Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 15 Oct. 66	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR OCT 14 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
13562					CERTIFICATE OF DEATH					13561							
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum c. LENGTH OF STAY IN 1b 13 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 206 Nursery Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum d. STREET ADDRESS 206 Nursery Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Nora Louise Blann First Nora Louise Middle Blann Last Blann					4. DATE OF DEATH October 16, 1966 Month October Day 16 Year 1966												
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1875		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Easton, Maryland				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John Elms					14. MOTHER'S MAIDEN NAME Martha Tarr												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unkn.		17. INFORMANT Edward C. Blann				Address Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio-sclerosis - Cardiovascular (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis										INTERVAL BETWEEN ONSET AND DEATH 8 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Sept 4, 1966 to 9/25 , 19 66 , that (I) (we) last saw the deceased alive on 9/25/66 19 66 , and that death occurred at 8:00 M, from the causes and on the date stated above.																	
22a. SIGNATURE Dr. Joseph N. Zierler										22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Dr. Joseph N. Zierler										22d. ADDRESS 2502 Eutaw Place							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/18/1966		23c. NAME OF CEMETERY OR CREMATORY Spring Hill				23d. LOCATION (City, town or county) (State) Easton, Maryland							
24. FUNERAL DIRECTOR ADDRESS Newnam Funeral Home Easton, Md.										25a. REC'D BY REGISTRAR OCT 19 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

13562

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>222 Bolivar, Brooklyn</u>	
3. NAME OF DECEASED (Type or print) <u>ROXIE</u> First <u>BROWN</u> Middle Last		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1900</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>RUBIN GREEN</u>		14. MOTHER'S MAIDEN NAME <u>LIZA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>173-03-9684</u>	
17. INFORMANT <u>RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Pulmonary Edema</u> 443X DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Hypertension with Coronary Arteriosclerosis</u> (b) <u>18 years</u> (c) <u>18 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 months</u> <u>18 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Porto-Vaginal Bleeding</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> , 19 <u>66</u> to <u>10/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> , 19 <u>66</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Guillermo S. Linsao</u> M.D.		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GUILLERMO S. LINSAO, MD</u>		22d. ADDRESS <u>7308 FURNACE Branch Rd Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, M.D.</u>
24. FUNERAL DIRECTOR <u>Charles W. Rice</u> ADDRESS <u>661 W. Borne St.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13563

1. PLACE OF DEATH o. COUNTY <u>ADCO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ADCO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXXXXXXXXXXX Annapolis</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Gen. Hosp.</u>				d. STREET ADDRESS <u>Bx 480A Rt. # 2</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Butts</u> Last <u>Butts</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>17</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-93</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Butts</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>702-18-5965</u>		17. INFORMANT <u>Mrs. Lillie M. Butts (wife) Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intercerebral hemorrhage</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>10/21/66</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1955

1955



13565

CERTIFICATE OF DEATH

13564

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 412 N. Duncan St.	
3. NAME OF DECEASED (Type or print) 3-#33335 Marie P. Carmine		4. DATE OF DEATH Month 10 Day 18 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1905
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland VIRGINIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Emmet Firebauch		14. MOTHER'S MAIDEN NAME Mary B. Bare	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-1093	
17. INFORMANT MR. WILLIAM R. CARMINE, SAME AS 4d Hospital Records		18. ADDRESS -----	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Atelectasis DUE TO (b) Mucus plugging of Tracheo-bronchial tree DUE TO (c) Carcinoma of left breast			INTERVAL BETWEEN ONSET AND DEATH 170 x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) von Recklinghausen's Neuro-fibromatosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 66	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 9/19 , 19 66 , to 10/18 , 19 66 that (I) (we) last saw the deceased alive on 10/18 , 19 66 , and that death occurred at 9:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/18/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-21-66	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR DATE OCT 21 1966	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7261

1990

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. **Police** along with form PM3. Page 5 may be retained for your files.

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1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13566

1. PLACE OF DEATH a. COUNTY HA CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY 1 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park		c. LENGTH OF STAY IN lb 4 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O. H. - North. Arkunde. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell Low		4. DATE OF DEATH Month 10 Day 7 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Carnochan		14. MOTHER'S MAIDEN NAME Catherine Russell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-6534	
17. INFORMANT Mildred Carnochan		Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4344 IMMEDIATE CAUSE (a) Cardiac disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhart		M.D.	
EXAMINER'S NAME (Type) E. Linhart		22. DATE SIGNED 10-7-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/66	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1952

2/1/52

Washington

Technical

Colonel Russell

High School

210-00-0000 High School Washington, D.C.

Washington, D.C.

and Hill Country

1952

1952

Technical School Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13567					13566				
1. PLACE OF DEATH a. COUNTY Anne Arundle County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover c. LENGTH OF STAY IN 1b 80 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box #207 Hanover Maryland					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE Maryland COUNTY Anne Arundle c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box #207 Hanover Maryland d. STREET ADDRESS Box #207 Hanover Maryland a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lillian Louise Chase First Middle Last			4. DATE OF DEATH Oct. 29, 1966 Month Day Year		5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 26, 1879 9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Gambrill's Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Arron Adams 14. MOTHER'S MAIDEN NAME Martha Ann Williams						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT Address Romeo Chase 3611 Fairview Ave.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Seriously</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1966 to Jan. 16, 1966, that (I) (we) last saw the deceased alive on Jan. 16, 1966, and that death occurred at 4 AM, from the causes and on the date stated above.									
22a. SIGNATURE Frank E. Shipley, M.D. 22c. PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.			22d. ADDRESS Savage, Md.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Saint's Rest Cemetery		23d. LOCATION (City, town or county) (State) Harmons Maryland		
24 FUNERAL DIRECTOR'S SIGNATURE Nutter Funeral Home-3035 W. North Ave. ADDRESS					25a. REC'D BY REGISTRAR DATE NOV 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1980

CONFIDENTIAL

1980

[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some fragments are visible, such as "CONFIDENTIAL", "1980", and "STATISTICAL RESEARCH".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13565

CERTIFICATE OF DEATH

13567

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 18 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 5704 Phillys Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33500 Eugene Cieri, Sr.		4. DATE OF DEATH Month 10 Day 26 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/16/81
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 10 Days 26 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURER	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Angelo Cieri		14. MOTHER'S MAIDEN NAME Foristina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-0509	
17. INFORMANT Hospital Records		Address MAILE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Arteriosclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Chronic Brain Syndrome - Parkinsonism DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome - Parkinsonism		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State) 10/8/1966 to 10/26/1966		21. I certify that (I) (this hospital) attended the deceased from 10/8/1966 , to 10/26/1966 , that (I) (we) lost the deceased alive on 10/26/1966 , and that death occurred at 7:30 M, from causes and on the date stated above.	
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 10/26/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS -----	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-66	
23c. NAME OF CEMETERY OR CREMATORY Catholic Cem		23d. LOCATION (City or Town) (County) (State) Bald. Md.	
24. FUNERAL DIRECTOR Forley-Corcoran & Co. - Catonsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

3761

2025

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13569

CERTIFICATE OF DEATH

13568

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL) GLEN BURNIE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 503 KINTOP ROAD		d. STREET ADDRESS 503 KINTOP ROAD	
3. NAME OF DECEASED (Type or print) First Harry Middle F. Last CLARK		4. DATE OF DEATH Month 10 Day 10 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1885
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CLARK		14. MOTHER'S MAIDEN NAME THERESA MITE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 187-03-5472 A	
17. INFORMANT MRS. MARY C. CLARK, 503 KINTOP ROAD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Arteriosclerosis general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June, 1966, to Oct 10, 1966, that (I) (we) last saw the deceased alive on 10/11/1966, and that death occurred at 9:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Joseph Taler		22b. DATE SIGNED 10/10/66	
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER		22d. ADDRESS 95 Aqueduct Rd. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-13-66	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229		25a. REC'D BY REGISTRAR DATE OCT 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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OFFICE OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
13570					13570										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hamletts</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hamletts</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>Joseph Conway</u> First Middle Last					4. DATE OF DEATH <u>10 4 1966</u> Month Day Year										
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-1915</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Conway</u>					14. MOTHER'S MAIDEN NAME <u>Grace Holloway</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr. E. Skeritt - Hamletts Md.</u> Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1946</u> to <u>Oct 3, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 19, 1966</u> and that death occurred <u>8:30 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Edward Skeritt</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia</u>				23d. LOCATION (City, town or county) <u>Edenton, Md.</u> (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u> ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								
DATE <u>OCT 6 1966</u>															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM HEIGHTS		c. LENGTH OF STAY IN 1b Ft. Geo. G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM HEIGHTS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 501 DARLENE AVENUE / Kimbrough Army Hospital DOA				d. STREET ADDRESS 501 DARLENE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle CLIFFORD Last CRAIG				4. DATE OF DEATH Month OCTOBER Day 31 Year 1966			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JAN 6, 1922		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Serviceman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Dean Reed				14. MOTHER'S MAIDEN NAME Craig			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Unknown		16. SOCIAL SECURITY NO. 232-24-7760		17. INFORMANT Mrs. D. Craig, 501 Darlene Ave Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DOA 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary arteriosclerotic Heart Disease, severe pulmonary edema, marked						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased the deceased from from was DOA was DOA , XX XX 31 Oct. 31 Oct. , 19 66 66 , that death occurred at 6:40 a.m. and that death occurred at 6:40 a.m. , from causes and on the date stated above.							
22a. SIGNATURE Sherwood Cohen, CPT MC				22b. DATE SIGNED 31 OCT 66		22c. PHYSICIAN'S NAME (Type) SHERWOOD COHEN, CPT, MC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM'L PARK		23d. LOCATION (City or Town) (County) (State) ELK RIDGE, HOWARD CO. MD.	
24. FUNERAL DIRECTOR R.V. SINGLETON				25a. REC'D BY REGISTRAR NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

13572

Item #2a, b, & c film #G382 11/2/66 pc

13572

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Glen Burnie</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>City/Hosp: Md</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>808 Reservoir St.</u> <u>7355 FURNACE BLANCH RD</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> <u>Cruse</u>		4. DATE OF DEATH <u>October 24</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1899</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		11. BIRTHPLACE (County & State, or foreign country) <u>UNKNOWN Md</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>705-12-3806</u>	
17. INFORMANT <u>Joseph Noel</u>		Address <u>514 Ellen St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertensive Cardio-Vascular</u> DUE TO <u>Chronic Brain Syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 3, 1965</u> to <u>October 24, 1966</u> that (I) (we) last saw the deceased alive on <u>October 24, 1966</u> and that death occurred at <u>11 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Hunt</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>		22d. ADDRESS <u>100 Chury Lane, Glen Burnie, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethg. Mth. Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Eber</u>		25a. REC'D BY REGISTRAR <u>Oct 27 1966</u>	
ADDRESS <u>1518 N. Allen St</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13572

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13573

1. PLACE OF DEATH a. COUNTY <u>A. ACU</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HACO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9/EN BURRIE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9/EN BURRIE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LOMBARDY BEACH, VIEW POINT, GLEN BURNIE</u>					d. STREET ADDRESS <u>41-Box 2260</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Theresa</u> First <u>E.</u> Middle <u>XXXXXX</u> Last <u>DiSaia</u>				4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 8, 1899</u>		9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months <u>29</u> Days <u>19</u> Hours <u>00</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HATTER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET TWIST</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mr. Joseph L. DiSaia, 3653 McTavish Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO (b) <u>975X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Asphyxiation</u> DUE TO (b) <u>Asphyxiation</u> DUE TO (c) <u>Asphyxiation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Asphyxiation</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped 17' over into water</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lombardy Beach</u>		20f. (City or town) (County) (State) <u>HACO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>		EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D.		22. DATE SIGNED <u>10-29-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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John Deere

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John Deere

John Deere

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John Deere

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13574

13574

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AnneArundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 20 North Homeland Ave.,	
3. NAME OF DECEASED (Type or print) Kenneth Harrison DUCKETT, Sr.		4. DATE OF DEATH Month October Day 16 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1889
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING RET. PRINCE GEO. Co. Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME STEPHEN W. DUCKETT		14. MOTHER'S MAIDEN NAME MARY HOPKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Dorothy W. DUCKETT #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of right rib		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as hospital) attended the deceased from 7:50 AM , 19 Oct. 16 , 19 66 that (I) (we) saw the deceased alive on Oct. 16 , 19 66 , and that death occurred at 9:50 AM from causes and on the date stated above.			
22a. SIGNATURE F.M. SHIPLEY		22b. DATE SIGNED 10-12-66	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-18-66	
23c. NAME OF CEMETERY OR CREMATORY DAVIDSONVILLE METH.		23d. LOCATION (City or Town) (County) (State) DAVIDSONVILLE MD.	
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13575

CERTIFICATE OF DEATH

13575

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 02-1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 1, Box 406 K4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise Lentz		4. DATE OF DEATH October 23 19 66		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1931	
9. AGE (In years last birthday) 35 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		11. BIRTHPLACE (County & State, or foreign country) COLDWATER MISS.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME V. STEVE LENTZ		14. MOTHER'S MAIDEN NAME MAGGIE WADE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-44-3652		17. INFORMANT MAURICE J. EAD #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Coma DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Malastate DUE TO (c) to liver.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on OCT 23 1966 , and that death occurred at 2:55 A.M.		22a. SIGNATURE Stephen B. Hiltabidle	
22b. DATE SIGNED OCT 24 '66		22c. PHYSICIAN'S NAME (Type) STEPHEN B. HILTABIDLE		22d. ADDRESS 121 CATHEDRAL ST ANNAPOLIS MD	
23a. BURIAL CREMATION, (Specify) BURIAL		23b. DATE THEREOF OCT 25 1966		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM	
23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.		24. FUNERAL DIRECTOR JOHN M. TAYLOR, SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR OCT 25 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. (City or town) (County) (State)		25d. (City or town) (County) (State)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13576 CERTIFICATE OF DEATH 13576									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL					d. STREET ADDRESS ANNAPOLIS, MD BAYRIDGE AVE & VAN BUREN ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last THOMPSON PHELPS ELLIOTT			4. DATE OF DEATH Month Day Year OCTOBER 1 19 66						
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 AUGUST 1902		9. AGE (in years last birthday) 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT. U. S. NAVY RET			10b. KIND OF BUSINESS OR INDUSTRY U. S. NAVY			11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME RICHARD G. ELLIOT					14. MOTHER'S MAIDEN NAME JULIA V. HAMMON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. 21 YEARS 220-44-6672		17. INFORMANT RICHARD H. ELLIOTT BROTHER		Address ANNAPOLIS NURSING HOME, ANNA, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8 SEPT 66, 1966, to 1 OCTOBER 19 66, that (I) (we) last saw the deceased alive on 1 OCTOBER 1966, and that death occurred at 8:15 PM, from the causes and on the date stated above.									
22a. SIGNATURE Barney John Coughlin M.D.					22b. DATE SIGNED 1 OCTOBER 1966				
22c. PHYSICIAN'S NAME (Type) B. J. COUGHLIN, LT MC USN					22d. ADDRESS USNH ANNAPOLIS, MARYLAND 21402				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 10-4-66		23c. NAME OF CEMETERY OR CREMATORY ST. ANNE'S		23d. LOCATION (City, town or county) (State) ANNAPOLIS MD		
24. FUNERAL DIRECTOR John M. Lytessons Annapolis, Md.					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge DATE OCT 4 1966				

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Amnopolis MD

John W. Lupton Amnopolis MD
10-4-46 St Anne's

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13577

CERTIFICATE OF DEATH

13577

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 1 year 3 mos. 7 das.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1602 E. Monument Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #29710 Viola		First Viola		Middle Elliott		Last Elliott		4. DATE OF DEATH Month 10 Day 19 Year 66	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH - - 1926 ?		9. AGE (In years last birthday) yrs. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 225-46-7096		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/12/1965 , to 10/19/1966 , that (I) (we) last saw the deceased alive on 10/19/1966 , and that death occurred at 7:45 M. , from causes and on the date stated above.									
22a. SIGNATURE L. Benedict, M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/19/66			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.				22d. ADDRESS -----					
23a. BURIAL, CREMATION, REMOVAL (Specify) -----		23b. DATE THEREOF 10-26-66		23c. NAME OF CEMETERY OR CREMATORY Cof Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR William Reese #108 W WASH ST.				25a. REC'D BY REGISTRAR DATE OCT 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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13578
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN b 2 mos. 18 d.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 5225 DENMORE AVENUE			
3. NAME OF DECEASED (Type or print) First Helena Middle H. Last Ellis				4. DATE OF DEATH Month 10 Day 4 Year 1966			
5. SEX F		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1911	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician				10b. KIND OF BUSINESS OR INDUSTRY Beautician		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME Lucille White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO (b) Cardiovascular Heart Disease DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH hours years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ---- p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State) -----							
21. I certify that (I) (this hospital) attended the deceased from October 4, 1966 , to October 4, 1966 , that (I) (we) last saw the deceased alive on 10/4 1966 , and that death occurred at 6:25 AM , from the causes and on the date stated above.							
22a. SIGNATURE John H. Daughtery, M.D.				22b. DATE SIGNED 10/4/66			
22c. PHYSICIAN'S NAME (Type) John H. Daughtery, M. D.				22d. ADDRESS Crownsville State Hospital Crownsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/12/66		23c. NAME OF CEMETERY OR CREMATORY N of Md.		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR William Leese, II - Annap. Md.				25a. REC'D BY REGISTRAR OCT 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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John H. Langley, M.D.

13579

CERTIFICATE OF DEATH

13579

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hettie Elizabeth ENNIS		4. DATE OF DEATH Month Day Year October 22 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY **	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -**		16. SOCIAL SECURITY NO. 214-54-1697	
17. INFORMANT Josephine A. Burley		Address Bristol, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) circulo-vascular accident DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from 1936 , to Oct. 22, 1966 , that (I) last saw the deceased alive on Oct 21 , 19 66 , and that death occurred at 6:50 pm , from causes and on the date stated above.			
22a. SIGNATURE Emily H. Wilson		22b. DATE SIGNED 10/24/66	
22c. PHYSICIAN'S NAME (Type) Emily H. Wilson, M.D.		22d. ADDRESS Lothian, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/25/66	23c. NAME OF CEMETERY OR CREMATORY Union chapel	23d. LOCATION (City or Town) (County) (State) Anne Arundel, Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md		25a. REC'D BY REGISTRAR DATE OCT 28 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STEFAN R. C.

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CONCLUSION

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Abstract

Dr. J. J. J. J.

214-14147 Josephine A. Bailey

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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W. J. H. 1901

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В. И. Ленин

FOR STATE
HEALTH DEPT.

13580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13580

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>P. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALCO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie - red. 02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL HOSP.</u>		d. STREET ADDRESS <u>Rt. 2 - Box 332</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>A</u> Last <u>Ewing</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-13</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard A. Ewing</u>		14. MOTHER'S MARRIAGE NAME <u>Florence O'Brien</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Laurette Ewing (wife)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>10-11-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, MD.</u>
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS Funeral Home <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

19220

19220

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A-A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A-B</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Connano Lovern-Severn Ave.</u>		d. STREET ADDRESS <u>301 Severn Av.</u>	
3. NAME OF DECEASED (Type or print) <u>HENRY R. FAUVER</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>31</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cover - Bar</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Fauver</u>		14. MOTHER'S MARDEN NAME <u>Violet?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Helen Fauver - Above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound skull</u> 976X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted gun shot wound skull</u>	
20c. TIME OF INJURY Hour <u>10</u> p.m. <u>10/31</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>BAR -</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>BAR -</u>		20f. (City or town) (County) (State) <u>ANNE ARD MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D.	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>10/31/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-3-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie A.A. Md</u>	
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>		25a. REC'D BY REGISTRAR <u>Severna R. W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 4 1966</u>	

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James H. Funder

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item # 1d F # G382 10/7 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13582 Items 7, 22b Film G381 10/21/66 mh 13582													
1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Franklin Manor</u> c. LENGTH OF STAY in b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gloucester St.</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kentland, Md.</u> d. STREET ADDRESS <u>7601 Hawthorne St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Sylvia Edith Greening</u> First Middle Last 4. DATE OF DEATH <u>Oct 14</u> 19 <u>66</u> Month Day Year						5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 3, 1889</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Hinsdale, N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>						13. FATHER'S NAME <u>Brezelle STORRS</u> 14. MOTHER'S MAIDEN NAME <u>Lucretia MAINE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Gordon Greening Churchton</u> Address <u>MD</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous cerebral thrombosis & paralysis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> to <u>Oct 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 14, 1966</u> , and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Willard F. Smith</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith MD</u>						22b. DATE SIGNED <u>10/14/66</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Shady Side, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maplehurst</u>				23d. LOCATION (City, town or county) <u>Maplehurst N.Y.</u> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hershey Funeral Home</u> ADDRESS <u>Annapolis, Md</u>						25a. REC'D BY REGISTRAR <u>OCT 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

13583

13583

Order of the Court

James M. Smith

James M. Smith

James M. Smith

CERTIFICATE OF DEATH

13584

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 2mos. 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 508 d. STREET ADDRESS Adelena e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#32827 Moses Gross		4. DATE OF DEATH Month 10 Day 11 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 19, 1921
9. AGE (In years last birthday) yrs. 45		10. IF UNDER 1 YEAR Months 10 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Worker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Gross		14. MOTHER'S MAIDEN NAME Annie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Respiratory Insufficiency; Severe Emphysema; DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 66	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 7/30 , 19 66 , to 10/11 , 19 66 , that (I) (we) last saw the deceased alive on 10/11 , 19 66 , and that death occurred on 9 A. M., from causes on and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 10/11/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) -----	23b. DATE THEREOF 10-19-66	23c. NAME OF CEMETERY OR CREMATORY U.S. Med. School	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR William Reese H.		25a. REC'D BY REGISTRAR OCT 21 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

第 2 次

1328

13584

CERTIFICATE OF DEATH

13585

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 19 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Delham Farm, Box 82, Rt. 3		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Anna Maria HAMMOND		4. DATE OF DEATH Month Day Year October 15 1966							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1916		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Defense Plant		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Richard N. Hammond		Address Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO (b) 178X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) did not attended the deceased from June , 19 66 , to Oct. 15 , 19 66 , that (I) did not saw the deceased alive on Oct. 14 , 19 66 , and that death occurred at 12:45 am M, from causes and on the date stated above.									
22a. SIGNATURE Richard I. Hochman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/15/66			
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin Street, Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-66		23c. NAME OF CEMETERY OR CREMATORY St. Anne		23d. LOCATION (City or town) (County) (State) St. Anne, Md.			
24. FUNERAL DIRECTOR Robert S. Barranco				ADDRESS Severna Park, Ind		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13584

EXHIBIT OF CLAIM

13584

Anne Arnold

Maryland

Anne Arnold

Anne Arnold

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1911--1912

Anne Arnold General Hospital

Golden Gate, Box 82, N.Y.

Anne

Maria

HAWAII

October 19

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White

August 19, 1918

Maryland

U.S.

Richard I. Noonan, N.Y.

50 Franklin Street, New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13585

13586

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Arnold
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-3, Box-284	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francis William HARGADON		4. DATE OF DEATH Month Day Year October 4 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 15, 1911
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CHAFFEUR POLICE DEPT.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT FRANK R. HARGADON Address 233 W. 21ST ST. N.Y.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary thrombosis DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 10 , 19 66 , to Oct. 4 , 19 66 that (I) (we) last saw the deceased alive on Oct. 4 , 19 66 , and that death occurred at 323 PM , from causes on and on the date stated above.			
22a. SIGNATURE R M Smith		22b. DATE SIGNED 10/4/66	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.		22d. ADDRESS HahnProfBldg., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT-7-1966	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City or Town) (County) (State) Ritchey Hgghy ARG Md	
24. FUNERAL DIRECTOR THOMAS J KENNY INC		25a. REC'D BY REGISTRAR OCT 5 1966	
ADDRESS 1600 Hollins		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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STATEMENT OF DEBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS Box 10, Rt. 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#23071 Samuel			First Middle Last Samuel Walter Harrison			4. DATE OF DEATH 10 10 1966		Month Day Year			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tractman				10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Basil Harrison						14. MOTHER'S MAIDEN NAME Maria					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ----		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----		20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 12/4 , 19 61 , to 10/10/66 , that (I) (we) last saw the deceased alive on 10/10 , 19 66 , and that death occurred at 8:30 , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/10/66			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.						22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/14/66		23c. NAME OF CEMETERY OR CREMATORY Holy Family		23d. LOCATION (City, town or county) (State) Mitchellville, Maryland				
24. FUNERAL DIRECTOR T. Stewart Jr.						25a. REC'D BY REGISTRAR Oct 13 1966		25b. REGISTRAR'S SIGNATURE [Signature]			

1855

1855

James Madison State Hospital
Box 10, N.E.
Richmond, Va.
Virginia

Sept. 10, 1900
U.S.A.
Hospital Records

James Madison State Hospital
Box 10, N.E.
Richmond, Va.
Virginia

Sept. 10, 1900
U.S.A.
Hospital Records

James Madison State Hospital
Box 10, N.E.
Richmond, Va.
Virginia

Sept. 10, 1900
U.S.A.
Hospital Records

James Madison State Hospital
Box 10, N.E.
Richmond, Va.
Virginia

CERTIFICATE OF DEATH

13587

13588

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>Rt #2</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE A. HASCHERT</u>		4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1924</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.P. TELEPHONE Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES W. HASCHERT</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE SEIPP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NFS</u>		16. SOCIAL SECURITY NO. <u>WWH</u>	
17. INFORMANT <u>DORIS HASCHERT</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute mytyle of the heart</u> <u>4222</u> DUE TO (b) <u>(cause unknown)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Several</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant melanoma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>66</u> , to <u>10/24/66</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Albert L. Anderson</u>		22b. DATE SIGNED <u>10/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON</u>		22d. ADDRESS <u>SOUTH GATE AVE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-25-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Arlington</u>	23d. LOCATION (City or Town) (County) (State) <u>Va.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 25 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1351

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and (1) any event within 72 hours after death.

VR A1SME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

13588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13589

1. PLACE OF DEATH o. COUNTY <u>A.A. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>965 BURNIE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lincolnton - Md</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>0017 - NORTH. HAVINDIEL</u>				d. STREET ADDRESS <u>404 Fresh View Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>H.</u> Last <u>Hennery</u>				4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>84</u> yrs.	
9. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse - Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry W. Herman</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Dehrl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-8451</u>		17. INFORMANT <u>Miss Rosella Herman</u> Address <u>4000 Chatham Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Atherosclerosis generalized</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Howard</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
		Address (Street, city, town, or county) <u>10-10-66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/12/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR <u>Lickner Fred. Baltimore Md 21217 with 2 daughters</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1927

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13589

13590

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 215 Tilghman St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Middle Last HIGGINS		4. DATE OF DEATH Month October Day 13 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1892	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (County & State, or foreign country) Md Savage Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Mitchell Barnard				14. MOTHER'S MAIDEN NAME Minnie Bogue			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Thomas Murphy Annapolis Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from 10-12-66 , 19 66 , to Oct. 13 , 19 66 , that (I) last saw the deceased alive on Oct. 13 , 19 66 , and that death occurred at 7:40 AM M, from the causes and on the date stated above.							
22a. SIGNATURE Aris T. Allen				22b. DATE SIGNED 10-13-66			
22c. PHYSICIAN'S NAME (Type) ARIS T. ALLEN				22d. ADDRESS 62 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/66		23c. NAME OF CEMETERY OR CREMATORY St. George Cem		23d. LOCATION (City, town or county) (State) Mt Savage Md	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR 10-17-66 DATE			

1350

1350

James Arnold

1 day

James Arnold of Central Hospital

112 Thomas St.

HINDS

May 11, 1902

James

James

Richard Smith, School
Mitchell Bannock

James B. Jones

Mr. James B. Jones

XXXXXX

Oct. 13, 1902

Oct. 13

Oct. 13, 1902

James B. Jones

James B. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD
13590
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
11/3/66
13591

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md</u>		c. LENGTH OF STAY IN 1b <u>02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hosp</u>		d. STREET ADDRESS <u>29 5th Ave - S.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Belle</u> ^{first} <u>C.</u> ^{middle} <u>Hill</u> ^{last}		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1874</u> AGE (In years last birthday) <u>92</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Condon</u>		14. MOTHER'S MAIDEN NAME <u>? Family name</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family name</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organic brain syndrome</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic cerebrovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Incisional abdominal hernia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>66</u> , to <u>10/26</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> and that death occurred at <u>6 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>George Vash</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>VASH</u>		22d. ADDRESS <u>206 S. Lincoln</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>10/29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>McCully</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 27 1966</u>	
ADDRESS <u>130 E. Baltimore Ave. #30</u>		25b. REGISTRAR'S SIGNATURE <u>Johnes Judge</u>	

12051

9253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

-13592

CERTIFICATE OF DEATH

Reg. Dist. No. 13592

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape St. Claire				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 240 Route 4 Harbor View Drive				d. STREET ADDRESS Box 240 Route 4 Harbor View Drive			
3. NAME OF DECEASED (Type or print) EPBridg First C Middle HILL Last				4. DATE OF DEATH Month 10 Day 11 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/16/1888	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tin Smith		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas S. Hill				14. MOTHER'S MAIDEN NAME Elizabeth Chickering			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-03-4542A		17. INFORMANT Mrs. Margaret L. Hill-Harbor View Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized cardio-vascular arteriosclerosis, 10 years plus DUE TO (c) chronic cardiac failure 8 months				INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8-24 , 19 50 , to 10-11 , 19 66 , that I last saw the deceased alive on 10-10 , 19 66 , and that death occurred at 3:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bertrand C.R. Gau				ADDRESS (Street, city or town, state) Box 177 - R.F.D. #4			
PHYSICIAN'S NAME (Type) Bertrand C.R. Gau				DATE SIGNED Cape St. Claire Annapolis Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/13/66		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers-8728 Liberty Rd. Randallstown, Md.				24a. REC'D BY REGISTRAR OCT 13 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13592				13593			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 301 W. Greenwood Rd.				d. STREET ADDRESS 301 W. Greenwood Rd.			
3. NAME OF DECEASED (Type or print) First Raymond J. Hill Sr. Middle Last 				4. DATE OF DEATH Month Oct. Day 23 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1903	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Fabric		11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John T. Hill				14. MOTHER'S MAIDEN NAME Sophia Dean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216 32 8522		17. INFORMANT Mrs. Mary A. Hill		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. WHAT WAS CAUSED BY: IMMEDIATE CAUSE (a) Bands pneumonia 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) reticulum cell sarcoma OUE TO (c) with metastases						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 15, 1966 to 10-23-66 19 66 , that (I) (we) last saw the deceased alive on 10-23-66 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frantz X. Groll						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frantz X. Groll						22d. ADDRESS 5 Central Ave. Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 27 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City, town or county) (State) Glen Burnie, A. A. Co Md	
24. FUNERAL DIRECTOR Mc Gully				25a. REC'D BY REGISTRAR 130 E. Fort Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	

1951

19361

13598

CERTIFICATE OF DEATH

13594

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2mos. 7days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian		d. STREET ADDRESS Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33129 Lulu Walters Hunt		4. DATE OF DEATH Month 10 Day 4 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/84
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (retired)		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Hunt		14. MOTHER'S MAIDEN NAME Rebecca Hunt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebral Vascular Accident			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/27/66 , to 10/4/66 , that (I) (we) lost saw the deceased alive on 10/4/66 , and that death occurred at 6:05 M, from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 10/4/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Oct 7, 1966	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City or Town) (County) (State) Galesville, Md
24. FUNERAL DIRECTOR HARDESTY Funeral Home, Galesville, Md		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A2261

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1992

1991-1992

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

(M)

13594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13595

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rte 2 Box 242 Dundee Road		d. STREET ADDRESS Rte.10 Box 257 Lake Shore	
3. NAME OF DECEASED (Type or print) First Dennis Middle ABRAHAM Last HUTSON		4. DATE OF DEATH Month October Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-42
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FINE METAL CASTING		10b. KIND OF BUSINESS OR INDUSTRY Copper Refinery	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. HUTSON, SR.		14. MOTHER'S MAIDEN NAME MAUDE A. DRISCOLL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-40-0688	
17. INFORMANT Mrs. MAUDE A. HUTSON (MOTHER)		Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of face 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject shot during altercation	
20c. TIME OF INJURY Hour 10:00 p.m. Month, Day, Year 10-30 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) porch		20f. (City or town) (County) (State) Dundee Road Rt. 2 Box 242 A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		M.D.	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED October 31, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 3, 1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) BROOKLYN - A.A. CO., MD.	
24. FUNERAL DIRECTOR CURTIS E. EVANS		ADDRESS BALTO. MD.	
25a. REC'D BY REGISTRAR NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13234

13234

CURTIS E. EVANS

CERTIFICATE OF DEATH

13595

13596

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 10 Greenfield Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha JOHNSON				4. DATE OF DEATH Month Day Year October 18 19 66			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1911		9. AGE (In years last birthday) yrs. 55	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Johnson				14. MOTHER'S MAIDEN NAME Cornie C. Hew			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-186966		17. INFORMANT Address Rebecca Hall C. Hew			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Cerebral Hemorrhage DUE TO Arteriosclerotic Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1966 to 10/18/66 , 19 66 , that (I) (we) last saw the deceased alive on 10/18/66 , 19 66 , and that death occurred at 10:10 A.M. M. from causes and on the date stated above.							
22a. SIGNATURE B. L. Richardson				22b. DATE SIGNED 10/19/66		22c. PHYSICIAN'S NAME (Type) B. L. Richardson M.D.	
22d. ADDRESS 110 CHAY ST ANNAPOLIS, MD				22e. LOCATION (City or Town) (County) (State) Annapolis MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-22-66		23c. NAME OF CEMETERY OR CREMATORY Astbury		23d. LOCATION (City or Town) (County) (State) Annapolis MD	
24. FUNERAL DIRECTOR William Reese & Anna M.				25a. REC'D BY REGISTRAR DATE OCT 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

428

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1650m 1
M
13596
M
13597
24 120
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CROWNSVILLE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>30-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>1 yr. 3 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <u>953 N. CHAPEL ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ERNEST JOHNSON</u>		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1908</u>
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS PAXTON</u>		14. MOTHER'S MAIDEN NAME <u>FAY ALLEN PAXTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHRONIC BRAIN SYNDROME SEC. ALCOHOLIC INTOXICATION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-----</u> p.m. <u>-----</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-2</u> , 19 <u>65</u> , to <u>10-5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-5</u> , 19 <u>66</u> , and that death occurred at <u>4A</u> M. from causes on and on the date stated above.			
22a. SIGNATURE <u>William Benedict</u>		22b. DATE SIGNED <u>10/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>10/12/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>William Reese, Jr. - Annapolis Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1501

UNITED STATES OF AMERICA

1951

John C. Smith

John C. Smith

John C. Smith

John C. Smith

John C. Smith

John C. Smith

John C. Smith

John C. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13598											
1. PLACE OF DEATH a. CDUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Anne Arundel General Hospital					d. STREET ADDRESS 1902 Lincoln Drive						
3. NAME OF DECEASED (Type or print) First WILLIAM Middle McKINLEY Last JONES					4. DATE OF DEATH Month Oct Day 25 Year 1966						
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22 -1898		9. AGE (In years last birthday) 68 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer			10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Calvert Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Jones					14. MOTHER'S MAIDEN NAME Mary Reid						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-14-3185		17. INFORMANT Katherine Chambers-307 West St. Anna. Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma (Generalized) 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 16, 1966 to Oct 25, 1966 , that (I) (we) last saw the deceased alive on Oct 23, 1966 , and that death occurred at 11 M, from the causes and on the date stated above.											
22a. SIGNATURE R.L. Richardson					22b. DATE SIGNED Oct 29, 1966						
22c. PHYSICIAN'S NAME (Type) R.L. Richardson					22d. ADDRESS 110 Clay St. Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 29-66		23c. NAME OF CEMETERY OR CREMATORY Davidsonville			23d. LOCATION (City, town or county) (State) Davidsonville, Md.			
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.					25a. REC'D BY REGISTRAR NOV 1 1966					25b. REGISTRAR'S SIGNATURE Charles Judge	

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James A. ...

James A. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP-1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13598											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 02-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo d. STREET ADDRESS Box 153 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last William Stanley Jones						4. DATE OF DEATH Month Day Year 10 28 1966					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1900		9. AGE (in years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grocer - retail				10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (County & State, or foreign country) Davidsonville, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Edward Jones						14. MOTHER'S MAIDEN NAME Edith May Fowler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 219-30-8024-A		17. INFORMANT Mrs. Leila E. Jones				Address same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 4201 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) unknown DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-3 , 19 66 to 10-27 , 19 66 , that (I) (we) last saw the deceased alive on 10-27 , 19 66 , and that death occurred at 9:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE W.P. Stephens						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-29-66			
22c. PHYSICIAN'S NAME (Type) William P. Stephens, M.D.						22d. ADDRESS 38 Cornhill St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/66		23c. NAME OF CEMETERY OR CREMATORY Edwards Chapel Cemetery			23d. LOCATION (City, town or county) (State) Riva Md.				
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME						ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR NOV 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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James Campbell

James Campbell

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James Campbell

James Campbell

James Campbell

Handwritten signature

James Campbell

James Campbell

James Campbell

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13599

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13582

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>5125 4th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5125 4th St. Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine E. Jordan</u>		4. DATE OF DEATH <u>10 10 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Williams</u>		14. MOTHER'S MAIDEN NAME <u>Louise Colbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>513-16-4592</u>	
17. INFORMANT <u>Adley Colbert Annapolis</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis - old</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sexual Abuse</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10021</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>10-10-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-13-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>	23d. LOCATION (City, town or county) (State) <u>St. Margaret MD</u>
24. FUNERAL DIRECTOR <u>William Reese # Annapolis</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 18 1966</u>			

13528

13528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Richard
Richard

Richard
Richard

11-10-22

CERTIFICATE OF DEATH

13600

13600

1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A A Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Glen Burnie,</i>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie,</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>101 COUNTRY CLUB DRIVE</i>				d. STREET ADDRESS <i>101 Country Club Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>M</i> Last <i>Kelly</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>11,</i> Year <i>1966</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>wh</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 4 1894</i>		9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months <i>72</i> Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>CONRAD SMITH</i>				14. MOTHER'S MAIDEN NAME <i>HINKEL</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>Mr. Kearney 101 Country Club Dr. Glen Burnie, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer - Vascular Disease</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Arterio-Sclerosis</i> DUE TO (c) <i>Hypertension</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2-3 mo</i> <i>2-4 yr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1964</i> to <i>1964</i> , that (I) (we) last saw the deceased alive on <i>10/11/1966</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles L. Ball</i>				22b. DATE SIGNED <i>10/12/66</i>		22c. PHYSICIAN'S NAME (Type) <i>Linthicum Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-14-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas J. Kenny Inc 1600 Hollins Balto. Md. 23</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13700

13700

CERTIFICATE OF DEATH

730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
2DM S-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13601						13601					
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21226</u> d. STREET ADDRESS <u>218 Greenland Beach Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ROBERTA</u> First <u>Anne</u> Middle <u>KELLY</u> Last			4. DATE OF DEATH Month <u>OCT.</u> Day <u>24</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Sept 1, 1913</u>			9. AGE (In years last birthday) <u>53</u>			10. IF UNDER 1 YEAR Months Days		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			12. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>			13. BIRTHPLACE (County & State, or foreign country) <u>Egypt</u>			14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. FATHER'S NAME <u>Richardson</u>			16. MOTHER'S MAIDEN NAME <u>Unknown</u>			17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			18. SOCIAL SECURITY NO. <u>220-22-2172</u>		
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Occlusion, Acute</u> (c), stating the underlying cause last. <u>Rheumatic calcific aortic stenosis</u>			20. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes, cirrhosis, diverticulosis</u>			22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			24. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.			25. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		
26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			27. (City or town) (County) (State)			28. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> to <u>Oct. 66</u> , that (I) <u>did</u> last saw the deceased alive on <u>Oct. 1</u> 19 <u>66</u> , and that death occurred at <u>7:45 PM</u> from the causes and on the date stated above.			29. SIGNATURE <u>C. Earl Hill</u> M.D.		
30. PHYSICIAN'S NAME (Type) <u>C. Earl Hill</u>			31. ADDRESS <u>395 Ft. Smallwood Rd., Pasadena, Md.</u>			32. DATE SIGNED <u>10-26-66</u>			33. REC'D BY REGISTRAR <u>Charles Judge</u>		
34. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			35. DATE THEREOF <u>Oct. 27, 1966</u>			36. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>			37. LOCATION (City, town or county) (State) <u>Frederick Ave, Balto, Md.</u>		
38. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gorce</u>			39. ADDRESS <u>169 Riviera Drive</u>			40. DATE <u>OCT 31 1966</u>			41. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1360

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15. 720

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13602					13602						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		Anne Arundel			a. STATE		b. COUNTY				
		MARYLAND			Maryland		Anne Arundel				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
Severna Park					Severna Park						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			
Route 1, Box 5, Jones Station Road					Rt. 1, Box 5, Jones Station Rd.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month	Day	Year	
ALBERT REYNOLDS KING						October		21	1966		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 25, 1897		68 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Watchman			Fertilizer Plant		Maryland			USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Alonzo J. King					Ada Virginia Reynolds						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
Yes			WW I		217 05 7491		Edith O. Morris, 1 Dunkirk Road Balto 21212				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion										unknown	
(c) Anterograde Cardiac degeneration											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from Aug 22, 1965, to 10/21, 1966, that (I) (we) last saw the deceased alive on 8/5th, 1966, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
Dr. Ray Smith					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
Dr. Ray Smith					Horn Building, Ritchie Hwy. Anne A. Co.						
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial			25 Oct 66		Woodlawn Cemetery		Woodlawn, Balto Co. Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Burgee Funeral Home, 3631 Falls Rd. Balto. Md.					DATE OCT 24 1966		Charles Judge				

5026

20261

2000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 382 11-1-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 18-21 Film 382 11-28-66 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13603

13603

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN lb 02-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle N. Last KIPP				4. DATE OF DEATH Month 10 Day 5 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-90	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store owner				10b. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? MD.							
13. FATHER'S NAME Frederick				14. MOTHER'S MAIDEN NAME —			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Family Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiovascular disease DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Laceration of lip							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which struck rear end of another auto.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:50 10 5 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway - Benfield Blvd. & Rt. 3		20f. (City or town) (County) (State) State AA Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) CHARLES S. SPRINGATE, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/8/66		23b. DATE THEREOF 10/8/66		23c. NAME OF CEMETERY OR CREMATORY Locust		23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR 414-237 Calapoco Co.				25a. REC'D BY REGISTRAR OCT 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13008

13008

13604

CERTIFICATE OF DEATH

13604

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, c. LENGTH OF STAY IN 1b Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) O.O.A. North Arundel Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS #109 First Ave., S/E e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH MAGDELEN KUPPE				4. DATE OF DEATH Month OCTOBER Day 9 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1903	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	IF UNDER 24 HRS. Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Shenandoah, Pennsy.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Grosskettler				14. MOTHER'S MAIDEN NAME Ida Beck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mr. Adolph J. Kuppe (husband) Address Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure DUE TO (b) Papert's Disease of the Brain DUE TO (c) Papert's Disease of the Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (the hospital) attended the deceased from Aug , 19 66 to death , 19 66 , that (I) (we) last saw the deceased alive on Oct 7 , 19 66 , and that death occurred at 2:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Wayne B. Tate		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/18/66			
22c. PHYSICIAN'S NAME (Type) Wayne B. Tate		22d. ADDRESS 108 Connel Ave					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF October 13/66	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn, RFD, Maryland			
24. FUNERAL DIRECTOR R.V. Singleton		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18804

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13605

CERTIFICATE OF DEATH

13605

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 66 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Priscilla Last Leitch		4. DATE OF DEATH Month 10 Day 1 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-82
9. AGE (In years last birthday) yrs. 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE CO., MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES B. CATHERTON		14. MOTHER'S MAIDEN NAME ELIZA KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. ELSIE MCGUCKIAN		Address # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) 10 YRS.			INTERVAL BETWEEN ONSET AND DEATH 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1 July , 19 66 , to 1 OCT , 19 66 , that (I) (we) last saw the deceased alive on 30 SEPT , 19 66 , and that death occurred at 5:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Charles F. Beck		22b. DATE SIGNED 10-1-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-4-66	23c. NAME OF CEMETERY OR CREMATORY FRIENDSHIP	23d. LOCATION (City or Town) (County) (State) FRIENDSHIP MD.
24. FUNERAL DIRECTOR John M. Fay & Sons		25a. REC'D BY REGISTRAR DATE OCT 6 1966	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12. *Chrysomelidae*

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James H. Davis

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13606

CERTIFICATE OF DEATH

13606

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 195 Duke of Gloucester St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jacqueline Bailey LEONARD		4. DATE OF DEATH October 21 1966		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 21, 1927		9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (County & State, or foreign country) Patterson, New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harry M. Leonard				14. MOTHER'S MAIDEN NAME Ethel Bailey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 142-20-9968		17. INFORMANT 700 Amerianca Dr., Mrs. Ethel B. Leonard- Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF BREAST, METASTATIC DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 1/2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from DEC 12, 1966 , to 21 OCT 1966 , that (I) (we) last saw the deceased alive on 20 OCT 1966 , and that death occurred at 6:05 A.M. M. from causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 10/21/66		22c. PHYSICIAN'S NAME (Type) Edward S. Beck		22d. ADDRESS Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Patterson Passaic N.J.	
24a. FUNERAL DIRECTOR Beverly E. Hopping		24b. ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR OCT 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20051

20265

CERTIFICATE OF DEATH

13607

13607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Lansdowne c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3520 Annapolis Rd.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Lansdowne d. STREET ADDRESS 3520 Annapolis Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last HELEN M. LEPKA			4. DATE OF DEATH Month Day Year October 6 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1908		9. AGE (In years last birthday) yrs. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Keeper		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Harry H. Geyman			14. MOTHER'S MAIDEN NAME Trautfelter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-24-5359	17. INFORMANT Address Walter H. Williams - 3608 Annapolis Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial Infarction DUE TO (c) 1 day					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 13, 1966 to Oct 6, 1966 that (I) (we) last saw the deceased alive on Oct 6, 1966 , and that death occurred at 9 A M, from causes and on the date stated above.					
22a. SIGNATURE Paul Schonfeld			22b. DATE SIGNED Oct. 7, 1966		22c. PHYSICIAN'S NAME (Type) Dr. Paul Schonfeld
22d. ADDRESS 2301 Annapolis Rd.			22e. REC'D BY REGISTRAR Charles Judge		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hgwy., Baltimore			25. REGISTRAR'S SIGNATURE Charles Judge		

18007

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CERTIFICATE OF DEATH

13608

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY IN TB 5 days		d. STREET ADDRESS Rt. 2, Box 509	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER LINK		4. DATE OF DEATH Month Day Year October 15 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY United Mine Worker	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Madison		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-07-5800	
17. INFORMANT James Link (same)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4-6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-10 , 1966, to 10-15 , 1966 that (I) (we) last saw the deceased alive on 10-14 - 1966 , and that death occurred at 5:35 AM , from causes and on the date stated above.			
22a. SIGNATURE William M. Herlihy		22b. DATE SIGNED 10-15-66	
22c. PHYSICIAN'S NAME (Type) H. T. O'HERLIHY		22d. ADDRESS 5 Cantwell Ave, Glen Burnie Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 18, 1966	23c. NAME OF CEMETERY OR CREMATORY Ward Cemetery	23d. LOCATION (City or Town) (County) (State) Ward, West Virginia
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR DATE OCT 18 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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13002

DEPARTMENT OF HEALTH

13002

Washington

June 1941

James O'Neil

data

Class 1000

U.S. Box 200

North Central General Hospital

October 1941

DATE

EXAMINE

May 19, 1941

NAME

U.S.

Virginia

United States

Refined

James O'Neil

under

92-87-200 James O'Neil

No

U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
WASHINGTON, D.C.

U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
WASHINGTON, D.C.

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BUREAU OF PUBLIC HEALTH
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13609

13609

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey	
c. LENGTH OF STAY IN 1b 40 Yrs.		d. STREET ADDRESS Rt. 2 Box - 358 (Ohio Ave.)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 2 Box - 358 (Ohio Ave.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES PHILIP LITTLE		4. DATE OF DEATH OCT. 31 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 March 1890
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint (ret)		10b. KIND OF BUSINESS OR INDUSTRY Gen Motors	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Little		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-09-8681	
17. INFORMANT Blanche S. Little - Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complications of age DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 1/2 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 13, 1966 , to Oct 31, 1966 that (I) (we) last saw the deceased alive on Oct 31, 1966 and that death occurred at 3:30 M, from causes and on the date stated above.			
22a. SIGNATURE B. Brumbaugh		22b. DATE SIGNED Nov 1 - 1966	
22c. PHYSICIAN'S NAME (Type) Bruce B. Brumbaugh		22d. ADDRESS 569 Main Elkridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 33 Nov. 66	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Howard Co., Maryland
24. FUNERAL DIRECTOR Eugene B. Thompson		25a. REC'D BY REGISTRAR DATE NOV 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1905

Figure 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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13610

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13610

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel General Hospital				d. STREET ADDRESS WILLOWDALE ST.-FERNDAL 442 WILLOWDALE ST.-FERNDAL			
3. NAME OF DECEASED (Type or print) First CHARLES Middle R. Last MAGERKURTH				4. DATE OF DEATH Month 10 Day 14 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-1903	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 03 Days 00		IF UNDER 24 HRS. Hours 00 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN				10b. KIND OF BUSINESS OR INDUSTRY BERT MACHINE CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES R. MAGERKURTH				14. MOTHER'S MAIDEN NAME ANNA C. HUH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) NONE				16. SOCIAL SECURITY NO. 220-14-0571			
17. INFORMANT MRS. GOLDIE M. MAGERKURTH, 442 WILLOWDALE STREET				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia							
9731 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbon Monoxide							
(a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhaled lawn mower's exhaust fumes			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-18-66		22c. NAME OF CEMETERY OR CREMATORY WESTERN CEMETERY		22d. LOCATION (City, town, or country) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229				24a. REC'D BY REGISTRAR OCT 19 1966			
				24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13611 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13611

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Main & Creek Rd.			
3. NAME OF DECEASED (Type or print) SANDRA LEE MALLE				4. DATE OF DEATH 10 4 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8/25/1944	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Ravel				14. MOTHER'S MAIDEN NAME Maher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Malle Jr.		Address As Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Gunshot wound of abdomen DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently shot self					
20c. TIME OF INJURY Month, Day, Year 12 Noon 9/16 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Pasadena Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/5/66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/66		22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Raymond C. Fink				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE OCT 10 1966 Charles Judge	

1931

MEDICAL EXAMINER CERTIFICATE OF DEATH

1931

FOR STATE

RECORDS

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
John Doe		45		Male		White		1931		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Occupation		Residence		Marital Status		Education		Previous Illnesses		Last Seen Alive		Time of Death		Temperature		Pulse		Respiration		Blood Pressure	
Teacher		123 Main St		Married		High School		None		1931		10:00 AM		98.6		72		18		120/80	
Family History		Social History		Hobbies		Religion		Military Service		Travel History		Autopsy		Burial		Disposition of Body		Disposition of Organs		Disposition of Tissues	
None		None		None		None		None		None		None		None		None		None		None	

FOR STATE

RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13612 CERTIFICATE OF DEATH 13612											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT GEO G. MEADE c. LENGTH OF STAY IN b 1/2 Hour d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN d. STREET ADDRESS Route #2, Box 241-A e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Mc Last CARTY						4. DATE OF DEATH Month OCTOBER Day 18 Year 19 66					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 17, 1906		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 02 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Serviceman				10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Mc CARTY						14. MOTHER'S MAIDEN NAME MINNIE WALLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 55I368064		17. INFORMANT (son) Mr. McCarty, Route #2 Box 241-A, Severn, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 443X DUE TO (b) ASCUD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive Cardio Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD, D diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH Hours Years Years											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 18 October , 19 66 to 18 Oct , 19 66 that (we) last saw the deceased alive on 18 Oct , 19 66 , and that death occurred at 8:15 M. from the causes and on the date stated above.											
22a. SIGNATURE Charles M Bliss Cpt me.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 18 Oct 66			
22c. PHYSICIAN'S NAME (Type) CHARLES M. BLISS, CPT, MC						22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-21-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR Harold S. Wad, Samuel Mc						25a. REC'D BY REGISTRAR OCT 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13513

13613

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> c. LENGTH OF STAY in lb <u>49 3</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Fulton</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ATLANTA</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM A McEACHIN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1966</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-2-1878</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Installations</u>		11. BIRTHPLACE (County & State, or foreign country) <u>McRAE, Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>DUNCAN CORNELIUS McEACHIN</u> 14. MOTHER'S MAIDEN NAME <u>MINERVA STEWART</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>252 1076 32A</u> 17. INFORMANT <u>John M. LEE</u> <u>RFD #1</u> Address <u>Box 536 Edgewater Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> (b) <u>myocardial infarction</u> (c) <u>arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>few hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> Hour a.m. <u>—</u> p.m. <u>—</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State) <u>—</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1965</u> to <u>Oct 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 19, 1966</u> , and that death occurred at <u>3:05 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ray M. Smith</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>SEVERNA PARK MD</u> 22b. DATE SIGNED <u>Oct 19, 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10-21-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WESTVIEW</u> 23d. LOCATION (City, town or county) (State) <u>ATLANTA Ga.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u> 25a. REC'D BY REGISTRAR <u>OCT 24 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ST. MARSHALLS

Bay of Islands

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M. J. J. J.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13614

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George L. Meade			c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kembrough Army Hospital			d. STREET ADDRESS Box 108		
3. NAME OF DECEASED (Type or print) 1666 Tina Marie MC NEAL			4. DATE OF DEATH October 30 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-56		9. AGE (In years lost birthday) 10 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MACON, GEORGIA	
13. FATHER'S NAME George Mc Neal			14. MOTHER'S MAIDEN NAME Hazel Wyatt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mr. George McNeal, Samd as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 8124 IMMEDIATE CAUSE (a) Cerebrocranial injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto			
20c. TIME OF INJURY 6:10 p.m. Oct. 30 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	
20f. (City or town) Rte. 198 Fort Meade Road		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		22. DATE SIGNED October 31, 1966	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3 Nov. 1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM	
23d. LOCATION (City or Town) ARLINGTON, VIRGINIA		(County)		(State)	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd, Laurel, Maryland		ADDRESS		25a. REC'D BY REGISTRAR NOV 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

1061

1061

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13615											
1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville Baltimore 21202							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1016 Lowe Street Crownsville State Hospital							
3. NAME OF DECEASED (Type or print) First NED Middle MEADOWS Last				4. DATE OF DEATH Month 10 Day 14 Year 1966							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1898		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Arundel Cont Co				11. BIRTHPLACE (State or foreign country) Oxford, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ned Meadows				14. MOTHER'S MAIDEN NAME Mary ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No				16. SOCIAL SECURITY NO. 219-03-6953				17. INFORMANT Mrs. Viola Langford 2516 Guilford Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9297 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Deceased found in water							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10 p.m. 19 66				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital grounds			
20f. (City or town) Crownsville				20g. (County) Anne Arundel				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/15/66 Address (Street, city, town, or county) Rudiger Breiteneker Herbert E. Nutter 3035 W. North Ave											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/22/66				22c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery			
22d. LOCATION (City, town, or country) Baltimore				22e. (State) Maryland							
23. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave				24a. REC'D BY REGISTRAR DATE OCT 24 1966							
24b. REGISTRAR'S SIGNATURE Charles Judge											

1990

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13616

CERTIFICATE OF DEATH

13616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 11 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 425 S. RITCHIE HWY				d. STREET ADDRESS 1125 NOTTINGHAM DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRENTON H. MEANS JR				4. DATE OF DEATH Month: OCTOBER 10, Day: 19, Year: 66			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 MARCH 1914	9. AGE (In years, months, days) 52 yrs.	IF UNDER 1 YEAR Months: Days: Hours: Min.	IF UNDER 24 HRS. Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY MISSILES PARTS		11. BIRTHPLACE (County & State, or foreign country) TYLER COUNTY		12. CITIZEN OF WHAT COUNTRY? YES	
13. FATHER'S NAME BRENTON H. MEANS Sr (dec)				14. MOTHER'S MAIDEN NAME BESSIE ANKROM (dec)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-05-7940		17. INFORMANT Wife: Mrs Shirley Means - Same address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 ACUTE CORONARY THROMBOSIS SUDDEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) ARTERIOSCLEROSIS 5 YRS DUE TO (c) OVERWEIGHT AND HYPERCHOLESTEROLEMIA 8 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE *** ASSISTANT MEDICAL EXAMINER NOTIFIED 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a.m. NO p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NO		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 June 1966 to present, 1966, that (I) (we) last saw the deceased alive on 10 Oct 1966, and that death occurred at 8:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE H.F. Manuzak				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H.F. MANUZAK				22d. ADDRESS 425 S. Ritchie Hwy, Glen Burnie, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/66		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park		23d. LOCATION (City, town or county) (State) Carroll County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Fink				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
				25b. REGISTRAR'S SIGNATURE f Charles Judge			

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**FOR STATE
HEALTH DEPT**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

13617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13617

1. PLACE OF DEATH a. COUNTY <u>AA.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.C.A. - North ARUNDEL -</u>		d. STREET ADDRESS <u>216 Rue 1he. Road. -</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Milleker</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10.23.15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>John Milleker</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-4345</u>	
		17. INFORMANT <u>Mrs. Erma R. Milleker, same as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic sclerosis generalis</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } b) _____ c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>10.11.66.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>18 Oct. 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Elkridge Howard, Md.</u>
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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THE UNIVERSITY OF CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13618						13618					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			e. STATE			b. COUNTY		
Anne Arundel			Glen Burnie			Md			Hawaii		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Glen Burnie			Plaza Manor Nursing Home			Jessup			7355 Farnwood Beach Rd		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Isreal			Jacob Miller			October 7 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
male		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 9, 1889		77 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Saw mill operator								Howard County Md			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Levi Miller				Mary Burner				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT			
(Yes, no, or unknown)				231-18-959				Mrs. J. Miller Jessup Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
4201. DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Acute Pulmonary Congestion											
(c) Hypertensive Cardiovascular Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 10-1-1966 to 10-7-1966 that (I) (we) last saw the deceased alive on 10-7-1966, and that death occurred at 8:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE											
Richard H. Hunt											
22b. DATE SIGNED 10-8-66											
22c. PHYSICIAN'S NAME (Type)											
Richard H Hunt											
22d. ADDRESS											
100 Cherry Lane, Glen Burnie, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
23b. DATE THEREOF											
10-10-66											
23c. NAME OF CEMETERY OR CREMATORY											
Ft Lincoln Ave											
23d. LOCATION (City, town or county) (State)											
Calmar Manor Md											
24. FUNERAL DIRECTOR'S SIGNATURE											
De Witt Connelley											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
OCT 13 1966											

13012

13012

CERTIFICATE OF DEATH

13619

13619

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 5 yrs. 1 mo.		d. STREET ADDRESS 302 N. Pearl Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #22784 Georgia		4. DATE OF DEATH Month 10 Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1906
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Salter		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic Pyelonephritis (c) Chronic Pyelonephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome, Pulmonary Emphysema, Inanition & Anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/19/1961 , to 10/5/1966 , that (I) (we) last saw the deceased alive on 10/5/1966 , and that death occurred at 6:20 P. M, from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED 10/6/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 10/12/66	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR William Reese, Jr. - Union Md.		25a. REC'D BY REGISTRAR DATE OCT 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13014

STATE OF TEXAS

County of ...

City of ...

State of Texas

County of ...

City of ...

State of Texas

County of ...

City of ...

State of Texas

County of ...

City of ...

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State of Texas

CERTIFICATE OF DEATH

13620

13620

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville St. Hosp.</i>		d. STREET ADDRESS <i>Box 383 Harold Harber</i>	
3. NAME OF DECEASED (Type or print) <i>Oliver</i>		4. DATE OF DEATH <i>October 12th 1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/22/89</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>state gov't</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-16-2808A</i>	
17. INFORMANT <i>Hospital Record.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>9/24</i> , 19 <i>66</i> , to <i>10/12</i> , 19 <i>66</i> that (I) (we) lost saw the deceased alive on <i>10/12</i> , 19 <i>66</i> , and that death occurred at <i>8:15</i> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <i>Alvin Thompson</i>		22b. DATE SIGNED <i>10/12/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i>		22d. ADDRESS <i>Crownsville State Hosp.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/15/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Our Lady of the Fields Cath.</i>	23d. LOCATION (City or Town) (County) (State) <i>Millersville A.A. Md.</i>
24. FUNERAL DIRECTOR <i>Dorothy E. Hopping</i> HOPPING FUNERAL HOME		25a. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>OCT 14 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

323

RSCG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13621

13621

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Annapolis Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, 15 institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>16 Franklin St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>BLAKE</u> Last <u>Norris</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Chelsea, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin S. Norris</u>		14. MOTHER'S MAIDEN NAME <u>Lois F. Clement</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. John C. Eakens</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> (c) <u></u> DUE TO OUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u>
PART II. OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/14</u> , 19 <u>66</u> , to <u>10/14</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>10/14</u> , 19 <u>66</u> , and that death occurred at <u>3:58</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.		22b. DATE SIGNED <u>10/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-17-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>
24. FUNERAL DIRECTOR <u>John M. Sayler & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
OCT 17 1966			

MEDICAL CERTIFICATION

18781

18781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A.														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Glen Burnie					c. LENGTH OF STAY IN 1b 5 days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Handover									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) N. Arundel General					d. STREET ADDRESS Box 4AA, Ridge Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) SALVATRICE First Middle Last					4. DATE OF DEATH October 5 1966 Month Day Year														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1882		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Italy					12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Thomas Cimino					14. MOTHER'S MAIDEN NAME Marie Grace Tamboro														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 212-54-9791T					17. INFORMANT Rosalie Sadler - (same)					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelosclerosis 446 X DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —										INTERVAL BETWEEN ONSET AND DEATH years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1962 to Oct 4 , 19 66 , that (I) (we) last saw the deceased alive on Oct 3 , 19 66 , and that death occurred at 10 PM , from the causes and on the date stated above.																			
22a. SIGNATURE [Signature]					22b. DATE SIGNED Oct. 7, 1966														
22c. PHYSICIAN'S NAME (Type) VASH					22d. ADDRESS 206 S. Green														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Oct. 8, 1966					23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery					23d. LOCATION (City, town or county) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore					25a. REC'D BY REGISTRAR OCT 10 1966					25b. REGISTRAR'S SIGNATURE [Signature]									

3361

De la Roche

13623

CERTIFICATE OF DEATH

13623

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 11mos. 16das.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 310 Magee Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) #30420 First Philip Middle Phillip Last Otto		4. DATE OF DEATH Month 10/ Day 11 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/1894
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months 10 Days 11 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown PHILIP OTTO SR	
14. MOTHER'S MAIDEN NAME Unknown CAROLINE STUMPF		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Arteriosclerosis DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome; Cor Pulmonale; Chronic Alcoholism			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/27/1965 to 10/11/1966 , that (I) (we) last saw the deceased alive on 10/11/1966 , and that death occurred at 5:10 A. M., from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/11/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/18/66	23b. DATE THEREOF 10/18/66	23c. NAME OF CEMETERY OR CREMATORY HILLSIDE	23d. LOCATION (City or Town) (County) (State) WILLOW GROVE, PA
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		25a. REC'D BY REGISTRAR 4107 WILKINS AVE BALTO. MD. 21220	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE OCT 17 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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13624

CERTIFICATE OF DEATH

13624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 Victor Parkway</u>		d. STREET ADDRESS <u>117 Victor Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>IDA</u> First Middle Last <u>C. PALMER</u>		4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	9. AGE (In years last birthday) <u>70</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Mifflin Township, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ANDREW CHINCILLA</u>		14. MOTHER'S MAIDEN NAME <u>GNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>WILLIAM F. PALMER</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> <u>1551</u> DUE TO <u>Carcinoma of gall bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-5</u> , 19 <u>66</u> , to <u>10-10</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9-22</u> 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Barber C. Palmer Jr.</u>		22b. DATE SIGNED <u>10-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BARBER C. PALMER JR.</u>		22d. ADDRESS <u>121 CATHEDRAL ST. ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-14-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City or Town) (County) (State) <u>JACKSONVILLE FLA.</u>
24. FUNERAL DIRECTOR <u>John M. Lyons Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

13032

RECEIVED

13031

RECEIVED
JAN 12 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNAPOLIS NURSING CENTER</u>		d. STREET ADDRESS <u>2 CARVEL RD. PENNENNIS MOUNT.</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>M^E ILROY</u> Last <u>PECK</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (County & State, or foreign country) <u>N. IRELAND</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. FATHER'S NAME <u>ROBERT M^E ILROY</u>		12. MOTHER'S MAIDEN NAME <u>ELIZABETH ORR</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. SOCIAL SECURITY NO. <u>107-10-7314</u>	
15. INFORMANT <u>KENNETH BROWN</u>		Address <u>#2</u>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/3, 1964</u> , to <u>10/29, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/20, 1966</u> , and that death occurred at <u>3:40 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>10/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman MD</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-1-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ALBANY RURAL</u>		23d. LOCATION (City, town or county) (State) <u>ALBANY N.Y.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 31 1966</u>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>H.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>FERRY Pt. ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>NICHOLAS</u> Middle <u>PHIPPS</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1897</u>
9. AGE (In years) Age <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES W. PHIPPS</u>		14. MOTHER'S MAIDEN NAME <u>ALBERTA MANGUN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>REGINA B. PHIPPS</u> #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>APR</u> , 19 <u>66</u> , to <u>7 OCT</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>7 OCT</u> , 19 <u>66</u> and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED <u>10/10/66</u>	
22c. PHYSICIAN NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>FRANKLIN ST ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-11-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it should be removed from the certificate and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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FORWARD THROUGH DOCS

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1 wk.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>*8468 Geniera Rd. (Sonsel Beh.)</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>J.</u> Last <u>Pitts</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1894</u>
9. AGE (In years last birthday) <u>72</u> YRS.		IF UNDER 1 YEAR: Months <u>29</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Franklin</u>		14. MOTHER'S MAIDEN NAME <u>Ida Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mr. Robert D. Smith (Husband) Samuels #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>1810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1810</u> DUE TO (d) <u>1810</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Myocardial Infarction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> , 19 <u>60</u> , to <u>Oct 29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 29</u> , 19 <u>66</u> , and that death occurred at <u>HP</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>C. R. MacDonald</u>		22b. DATE SIGNED <u>Oct. 30, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u>		22d. ADDRESS <u>*204 Crain Hwy. S.W. - Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, RFD, Md.</u>
24. FUNERAL DIRECTOR <u>R. Singleton</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 2 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Glen Burnie</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, 17</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Convalescent Home</u>		d. STREET ADDRESS <u>1207 N. Stricker St.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary M. Powell</u>		4. DATE OF DEATH <u>10 22 19 66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ramson Talley</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda G. Gignets</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-22-9024</u>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> 19 <u>59</u> to <u>Oct 22</u> 19 <u>66</u> . That (I) (we) last saw the deceased alive on <u>October 22 19 66</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Richard H. Hunt</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>		22d. ADDRESS <u>100 Cherryman, Glen Burnie, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-27-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave., Balto., Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13629 CERTIFICATE OF DEATH 13629										
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belvedere Beach c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 335 Alameda Parkway					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belvedere Beach d. STREET ADDRESS 335 Alameda Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Maude Middle S. Last Powell					4. DATE OF DEATH Month October Day 23 Year 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1878		9. AGE (in years last birthday) 87 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Albert Shackelford					14. MOTHER'S MAIDEN NAME Mary Catherine Wallace					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Mr. Frederick J. Singley, Jr. Bank Building			Address First National			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Right lower lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility & muscle weakness DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular disease								INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July , 19 65 , to Oct 23 , 19 66 , that (I) (we) last saw the deceased alive on Oct. 21 19 66 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Ray M. Smith M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 24 1966			
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH M.D.					22d. ADDRESS Hahn Prof. Bldg Severna Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/1966		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Wm. J. Tishman & Sons					ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR OCT 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt.-3, Box -550	
3. NAME OF DECEASED (Type or print) First HERBERT Middle (None) Last QUEEN		4. DATE OF DEATH Month October Day 16 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1899
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Queen		14. MOTHER'S MAIDEN NAME Anna Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 4201	
17. INFORMANT Rosa A. Queen		Address Gambrells	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute coronary thrombosis DUE TO (c) acute coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 , to Oct. 16, 19 66 , that (I) (we) saw the deceased alive on Oct. 16, 19 66 , and that death occurred at 7:50 PM from causes and on the date stated above.			
22a. SIGNATURE Edwin Smith, Jr.		22b. DATE SIGNED Oct. 16, 1966	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-19-66	23c. NAME OF CEMETERY OR CREMATORY Wilson Memorial	23d. LOCATION (City or Town) (County) (State) Gambrells Md
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 18 1966	

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NAME		13030	
ADDRESS		13030	
CITY		13030	
STATE		13030	
ZIP		13030	
TELEPHONE		13030	
OCCUPATION		13030	
EDUCATION		13030	
MARRIAGE		13030	
CHILDREN		13030	
RELIGION		13030	
POLITICAL		13030	
MILITARY		13030	
OTHER		13030	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital						d. STREET ADDRESS 293 A Solly Road				62-1	
3. NAME OF DECEASED (Type or print) First HENRY Middle B. Last RACHELS						4. DATE OF DEATH Month October Day 25 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1959		9. AGE (In years lost birthday) 7 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Laurinburg, N. C.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas B. Rachels						14. MOTHER'S MAIDEN NAME Ethel Lambert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----		17. INFORMANT Father - same as 2				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car							
20c. TIME OF INJURY Month, Day, Year 3:30 Hour 10 Day 25 Year 19 66 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Glen Burnie A.A. Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29 Oct. 66		23c. NAME OF CEMETERY OR CREMATORY McGirk Family Cemetery				23d. LOCATION (City or Town) (County) (State) Maxton, North Carolina			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.						25a. REC'D BY REGISTRAR OCT 31 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13632

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS 83 Northwest Street	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle RANDALL Last		4. DATE OF DEATH Month October Day 7 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis neonatorum 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED October 9, 1966	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL (CREMATION) REMOVAL (Specify)	23b. DATE THEREOF 10.25.66	23c. NAME OF CEMETERY OR CREMATORY U. Md. Med. School	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR OCT 28 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

11/7/66 Called Dr. Springate - Will let us know if it is possible to have autopsy performed. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13633									
CERTIFICATE OF DEATH									
13633									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c. LENGTH OF STAY IN b 2 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NORTH ARUNDEL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVIERA BEACH d. STREET ADDRESS 232 ASBURY ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSEPH GORDON ROHR			4. DATE OF DEATH OCTOBER 28 1966						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 6, 1910		9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COST ACCOUNTANT			10b. KIND OF BUSINESS OR INDUSTRY SCHENUIT RUBBER CO			11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES L.					14. MOTHER'S MAIDEN NAME JONES				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 216-01-0727		17. INFORMANT MRS EUNICE ROHR Address 232 ASBURY ROAD, PASADENA, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardio Vascular Disease									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JULY 1, 1964 , to 10/28, 1966 , that (I) (we) last saw the deceased alive on 10/20, 1966 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE J. Brady Smith					22b. DATE SIGNED 10/28/66				
22c. PHYSICIAN'S NAME (Type) J. BRADY SMITH					22d. ADDRESS RIVIERA BEACH, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF OCT 31, 1966		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City, town or county) (State) OLD FREDERICK RD, BALTO, MD		
24. FUNERAL DIRECTOR Graves & Gonsky					ADDRESS 4001 RITCHIE HWY, BALTO, MD		25a. REC'D BY REGISTRAR NOV 1 1966		25b. REGISTRAR'S SIGNATURE J. Charles Jr

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13634

CERTIFICATE OF DEATH

13634

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY IN 1b 10 Mons.		d. STREET ADDRESS #207 Greenway, N/W	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alberta Loretta Rumney		4. DATE OF DEATH October 23 19 66	
5. SEX female	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 12, 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Cedar Pt., St. Mary's Co. USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME L. Nota Readmond		14. MOTHER'S MAIDEN NAME Helen Stuart Walsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. None		16. SOCIAL SECURITY NO. 214-48-1441	
17. INFORMANT Mrs. Anna Mae Reese (daughter)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Anemia DUE TO (c) Leukemia, chronic lymphocytic			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 year 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aortic insufficiency, arteriosclerosis, hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 19 66 , to Oct 23 , 19 66 , that (I) (we) last saw the deceased alive on October 14 1966 , and that death occurred at 3:10 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Charles W. Kinzer</i>		22b. DATE SIGNED October 23, 66	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS South River Medical Center Edgewater, Maryland (21037)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 25, 1966	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Richard V. Singleton		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE OCT 25 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Anne Arundel

Annapolis

Annapolis Nursing Home

Runway

Alaska

1961, 1962, 1963

female, case

1961, 1962, 1963

Heart failure

Angina

Ischemic, chronic lymphocytic

Acute myocardial infarction, hypertension

October 14, 1961

October 14, 1961

October 14, 1961

Charles W. Kibbe, M.D.

October 14, 1961

October 14, 1961

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13635

CERTIFICATE OF DEATH

13635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove over-leaf papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis Cape St. Claire		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Rt-4, Box-326B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Margaret Last SCHALLINGER				4. DATE OF DEATH Month October Day 6 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1900	
9. AGE (In years last birthday) 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (Ret) Balto. City		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME August E. Wagener			
14. MOTHER'S MAIDEN NAME Anna M. Danker				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None			
16. SOCIAL SECURITY NO. 214-40-5571				17. INFORMANT (Brother) Mr. August H. Wagener Cape St. Claire, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 week (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from 10/1/66 , 19 66 , to Oct. 6, 1966 , that (I) (the physician) saw the deceased alive on Oct. 6, 1966 , and that death occurred at 10/6/66 M, from causes and on the date stated above.							
22a. SIGNATURE Gerard Church				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/2/66	
22c. PHYSICIAN'S NAME (Type) Gerard Church, M.D.				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10, 1966		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Richard V. Singleton				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR OCT 10 1966	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

13537

13538

RECORD OF DEATH

NAME

RESIDENCE

AGE

SEX

DATE

TIME

PLACE

CAUSE

DIAGNOSIS

TEST

AGE

DATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

Items 8, 9 Film G382 11/10/66 mh

13636

CERTIFICATE OF DEATH

13637

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>#200 Third Ave, S/E</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Bernard</u> Last <u>Schulz</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/1891</u>
9. AGE (In years last birthday) yrs. <u>74</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>Millhand (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Coast Guard</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Valentine A Schulz</u>		14. MOTHER'S MAIDEN NAME <u>Edith (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-36-1951</u>	
17. INFORMANT <u>Mr. Bernard R. Schulz (Son)</u>		Address <u>#202 Third Ave. S/E</u> <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> to <u>Sept 19, 1966</u> , that (I) (we) lost saw the deceased alive on <u>9-19-66</u> 19 <u>66</u> , and that death occurred at <u>9 P.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. MacDonald, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald, M.D.</u>		22d. ADDRESS <u>#204 Crain Hwy., S/W - Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 4, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, RFD, Md.</u>
24. FUNERAL DIRECTOR <u>RV Singleton</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>Singleton Funeral Home</u> <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13081

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RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
13638													
1. PLACE OF DEATH a. COUNTY <u>A. Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. Arundel</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10 HOLLOWAY Ave.</u>						d. STREET ADDRESS —							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>EMILY</u> Last <u>SELBY</u>						4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-1877</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Phillinger</u>						14. MOTHER'S MAIDEN NAME <u>Georgemna Shipley</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Mae Harding - Washington DC</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO (b) <u>Hypertensive cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>disease</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1964</u> , to <u>Oct. 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct. 24, 1966</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Edmond I. Moushabeck</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABECK</u>						22d. ADDRESS <u>510 HAXLEY STATION ROAD</u> <u>Glen Burnie, Md 21061</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sykesville, Md.</u>							
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 31 1966</u>													

1881

1881

STATE OF NEW YORK

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF NEW YORK" and "JANUARY" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13638

CERTIFICATE OF DEATH

13639

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Tracys Landing -RURAL	
3. NAME OF DECEASED (Type or print) First Middle Last William Moulden SHERBERT		4. DATE OF DEATH Month Day Year Oct. 9 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-07
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Sherbert		14. MOTHER'S MAIDEN NAME Annie Crosby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-38-3471	
17. INFORMANT Mrs. Naomi Ruppert Washington, D. C.		Address 6144 31st. St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure 580X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) hepatic necrosis cause unknown DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) alcohol			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-30 , 19 66 , to Oct. 9 , 19 66 that (I) (we) last saw the deceased alive on Oct. 9 , 19 66 , and that death occurred at 11:15 AM M, from causes and on the date stated above.			
22a. SIGNATURE Emily H. Wilson		22b. DATE SIGNED 10/10/66	
22c. PHYSICIAN'S NAME (Type) Emily Wilson, M.D.		22d. ADDRESS Lothian, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 12, 1966	
23c. NAME OF CEMETERY OR CREMATORY Friendship Chr. Cemetery		23d. LOCATION (City or Town) (County) (State) Friendship, A.A.Co. Md.	
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13033

13033

REMARKS ON DEATH

Time of death

Place of death

Age at death

Sex

Marital status

Color

Religion

Education

Occupation

Cause of death

Age

Place of birth

Place of death

33

John A. Harrison

John A. Harrison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13633					13640						
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold d. STREET ADDRESS Rt/ 1 Box - 96 B. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) JAMES C. SHERWOOD			4. DATE OF DEATH Oct. 10 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Sept. 1904		9. AGE (In years last birthday) 62 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret)			10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (County & State, or foreign country) N/C		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 409-30-0953		17. INFORMANT Arch L. Heady Funeral Home, Louisville, Ky.		
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery 443X DUE TO Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertension Cardiovascular disease (c) Hypertension Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 18 minutes 1 hr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 66 to 10/10 , 19 66 , that (I) (we) last saw the deceased alive on 10/10 , 19 66 , and that death occurred at 10:30 M, from the causes and on the date stated above.											
22a. SIGNATURE Guillermo Linsao M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Guillermo Linsao										22d. ADDRESS Glen Burnie, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12 Oct. 1966		23c. NAME OF CEMETERY OR CREMATORY Montevista Cemetery		23d. LOCATION (City, town or county) (State) Johnson City, Tenn				
24. FUNERAL DIRECTOR Robert P. Ware ADDRESS Singleton Funeral Home/Glen Burnie, Md.										25a. REC'D BY REGISTRAR OCT 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge											

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN lb 2 wks.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bay Manor N/ Home		d. STREET ADDRESS RFO 5 Box - 185	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle L. Last SMITH		4. DATE OF DEATH Month OCTOBER Day 16 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Oct. 1896
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (County & State, or foreign country) Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Micael Ward	
14. MOTHER'S MAIDEN NAME Anne L. Scham		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-05-48228		17. INFORMANT Herbert J. Smith - Same as # 2(husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Arteriosclerosis DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 10-16, 1966 , that (I) (we) last saw the deceased alive on 10-16, 1966 , and that death occurred at SEA , from causes and on the date stated above.			
22a. SIGNATURE F.M. SHIPLEY		22b. DATE SIGNED 10-12-66	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS ANNAPOLIS MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 19 Oct. 1966	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Robert Purse		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 18 1966	

13351

UNITED STATES DEPARTMENT OF JUSTICE

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VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13641
13642
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10 BREWER AVE</u>		d. STREET ADDRESS <u>10 BREWER AVE</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES R. SMITH</u>		4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ALAN SMITH</u>		14. MOTHER'S M maiden NAME <u>ANNIE HAWKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Dorothy E. Smith</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> <u>10 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF LUNG</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>66</u> to <u>13 OCT</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>13 OCT</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED <u>10-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>Franklin St. Annapolis, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-15-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 17 1966</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13642

CERTIFICATE OF DEATH

13643

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS #21 New Jersey Ave., N/W	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY EDWARD SMITH, JR.		4. DATE OF DEATH Month Day Year OCTOBER 17, 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1920
9. AGE (In years last birthday) yrs. 46		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY American Oil	
11. BIRTHPLACE (County & State, or foreign country) Colgate, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry E. Smith, Sr.		14. MOTHER'S MAIDEN NAME Beulah Hackett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 216 07 8776	
17. INFORMANT Mrs. Marie V. Smith (wife) Same As #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4201 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ lost. } DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-14- , 19 66 , to 10-17- , 19 66 , that (I) (we) last saw the deceased alive on 10-17- , 19 66 , and that death occurred at 7:20 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Ignas Saulynas, M.D.		22b. DATE SIGNED 10-17-1966	
22c. PHYSICIAN'S NAME (Type) Ignas Saulynas, M.D.		22d. ADDRESS 319 Old Annapolis Rd. Ferndale	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 20/66	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Parkk	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Singleton Funeral Home Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE OCT 20 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13643
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13644
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Pleasant</u>		c. LENGTH OF STAY in 1b <u>111111</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		d. STREET ADDRESS <u>Box 82 - Merly Creek Club</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O. A - North. ARUNDEL Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>S</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1966</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/65</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(unknown) Smith</u>				14. MOTHER'S MAIDEN NAME <u>Joan Diana Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Richard Stroud (Step-Grandfather) Same as</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Straining</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>See into Creek.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>See into Creek.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5.m.</u> <u>10/9</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Creek</u>		20f. (City or town) (County) (State) <u>ANCO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/9/66</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>October 12, 66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 13 1966</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13644

13645

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE, MD		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KIMBROUGH AH, FT GEO G. MEADE, MD		d. STREET ADDRESS 200 Ft Meade Rd	
3. NAME OF DECEASED (Type or print) SPAHN, DAVID (NMI) First Middle Last		4. DATE OF DEATH Month OCTOBER Day 29 Year 19 66	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 JAN 1898
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME MICHAEL SPAHN		14. MOTHER'S MAIDEN NAME BESS KRIEGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) 17 Nov 14-1 Apr 44		16. SOCIAL SECURITY NO. UNK	
17. INFORMANT Address JEWEL SPAHN(WIFE) 200 Ft Meade Rd. Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 October, 1966 , to 29 October, 1966 , that I last saw the deceased alive on 29 October, 1966 , and that death occurred at 9:00P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kimbrough AH, FCGMD DATE SIGNED 29 Oct 66			
ACTUAL SIGNATURE Benzion Benatar		PHYSICIAN'S NAME (Type) BENZION BENATAR	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13645

13646

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park c. LENGTH OF STAY IN 1b 10 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 410 Seward Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md., Anne Arundel b. COUNTY 02 - 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park d. STREET ADDRESS 410 Seward Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH KATHERINE SPENCER		4. DATE OF DEATH October 16 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1892
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Adam Helmstetter		14. MOTHER'S MAIDEN NAME Annie Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Margaret Spencer (same)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Cecal Appendix 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1957 , to 10/16, 1966 , that (I) (we) last saw the deceased alive on 10/15, 1966 , and that death occurred at 5:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Andrew R. Sosnowski		22b. DATE SIGNED Oct. 17, 1966	
22c. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski, M.D.		22d. ADDRESS 4016 Ritchie Highway	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1966	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy., A. A. Co., Md.	
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Mr. J. J. Anderson

Mr. J. J. Anderson

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13646

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13647

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN lb <u>3 Month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>38 Whetlin Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>Andrew</u> First <u>B.</u> Middle <u>Taylor</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 66</u> 9. AGE (In years lost birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kenneth Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Low Rodney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Kenneth Taylor</u> Address <u>Albino</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X Interstitial pneumonitis (SDii)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>10, 29, 66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/31/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	23d. LOCATION (City or town) (County) (State) <u>Glen Burnie A. H.</u>
24. FUNERAL DIRECTOR <u>Robert S. Barranco, Severna Park</u>		25. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>NOV 1 1966</u>	

13081

UNITED STATES DEPARTMENT OF AGRICULTURE

13081

Handwritten notes and signatures, including "J. H. ...".

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13647

CERTIFICATE OF DEATH

13648

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 503 Bowman Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Elizabeth THOMAS		4. DATE OF DEATH Month Day Year October 17 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 21, 1895
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Jones		14. MOTHER'S MAIDEN NAME Martha Pinkney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Johnson		Address Ann Arundel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertensive Cardiovascular disease (c) 22 days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-19-66 , 19 66 , to 10-19-66 , 19 66 , that (I) (we) last saw the deceased alive on 10-19-66 , 19 66 , and that death occurred at 1:10 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE W. T. Allen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. T. ALLEN		22d. ADDRESS 62 Colchester St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-20-66	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis Md	
24. FUNERAL DIRECTOR William Beese # Anna M.		25a. REC'D BY REGISTRAR DATE OCT 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12501

4361

CERTIFICATE OF DEATH

13648

13649

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CROWSVILLE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE STATE HOSP c. LENGTH OF STAY IN 1b 30-4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNSVILLE STATE HOSP				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 25 d. STREET ADDRESS 2716 WOODVIEW RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle THOMAS Last THOMAS				4. DATE OF DEATH Month 10 Day 29 Year 1966			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-1898	
9. AGE (In years, months, days) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Macon, Georgia	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME MAJOR POWELL			
14. MOTHER'S MAIDEN NAME ELIZ. POWELL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE - MYOCARDIAL INF. 4201 DUE TO ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME SEC. ARTERIOSCLEROSIS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-23 , 19 66 , to 10-29 , 19 66 that (I) (we) last saw the deceased alive on 10-29 , 19 66 , and that death occurred at 4P M, from causes and on the date stated above.							
22a. SIGNATURE Atvin Thompson M.D.				22b. DATE SIGNED 10/29/66		22c. PHYSICIAN'S NAME (Type) Atvin Thompson	
22d. ADDRESS Crownsville State Hosp.							
23a. BURIAL, CREMATION, OR DISPOSAL (City)		23b. DATE THEREOF 11/2/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) A A County Md	
24. FUNERAL DIRECTOR ADOLPHUS HALSTEAD L. 1206 W N North Ave.				25a. REC'D BY REGISTRAR DATE NOV 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

136310

136310

BALTIMORE 21
516 GOODVIEW BL

ESSEXVILLE STATE HOSP

THOMAS

LULA

1-1-1892

ELIZ POWELL

MAJOR POWELL

HEART FAILURE
ATHERIO-SCLEROTIC CARDIO-VASCULAR DISEASE

CHRONIC BRAIN SYNDROME SEC. ATHEROSCLEROSIS

10-21-01

44

9-23-01

44

10-21-01

10-21-01

13649

CERTIFICATE OF DEATH

13650

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE, MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, MD	
c. LENGTH OF STAY IN 1b 1 mo 23 days		d. STREET ADDRESS 3431 REISTERTOWN RD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First Middle Last		4. DATE OF DEATH OCT 15 19 66 Month Day Year	
5. SEX MALE	6. COLOR OR RACE NEG	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Serviceman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thompson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918 - 1948		16. SOCIAL SECURITY NO. 238-44-5623	
17. INFORMANT Mrs. Thompson, 3431 Reistertown Road, Balto, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic renal disease & Congestive Heart Failure DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 Month 23 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 28 Aug , 19 66 to 15 Oct , 19 66 that he (we) last saw the deceased alive on 15 Oct , 19 66 , and that death occurred at 11:45 M , from causes and on the date stated above.			
22a. SIGNATURE Lynn W. Holder		22b. DATE SIGNED 15 OCT 66	
22c. PHYSICIAN'S NAME (Type) LYNN W. HOLDER, CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 21 Oct. 1966	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.	23d. LOCATION (City or Town) (County) (State) ARLINGTON Va.
24. FUNERAL DIRECTOR Sheldon S. Wade, Samuel, Smd		25a. REC'D BY REGISTRAR DATE OCT 26 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

180304

CERTIFICATE OF DEATH

180304

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Occupation		Social Security Number	
Manner of Death		Signature of Physician	
Date of Report		Signature of Registrar	
County		State	
City		Zip Code	
Hospital		Physician	
Nurse		Medical Examiner	
Coroner		Jury	
Witnesses		Remarks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 5 yrs 10 mos. 11 da.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 2209 W. Saratoga Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) #21570 Annie Timberlake		4. DATE OF DEATH Month 10 Day 14 Year 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/1890
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 10 Days 14 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Rena Purnell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4221 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) ----- (c) -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro-Vascular Accident - Generalized Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 11/3 , 19 66 , to 10/14 , 19 66 , that (I) (we) last saw the deceased alive on 10/14 , 19 66 , and that death occurred at 3:20 M, from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 10/14/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 19, 1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem		23d. LOCATION (City or Town) (County) (State) A.A. County, Md.	
24. FUNERAL DIRECTOR ELLIOTT FUN. HOME N. CAROLINA		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

13051

DEPARTMENT OF STATE

13051

Washington

Washington

Department

Department

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Tulip Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Terrence Hugh TOBIN		4. DATE OF DEATH Month Day Year October 24 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1966
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1 - 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S/	
13. FATHER'S NAME John Richard Tobin		14. MOTHER'S MAIDEN NAME Mabel Frances Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a) RML PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (was is was) attended the deceased from Oct. 23 , 19 66 , to Oct. 23 , 19 66 , that (I) (we) lost saw the deceased alive on Oct. 23 , 19 66 , and that death occurred at 2:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Sherman S. Robinson</i> M.D.		22b. DATE SIGNED 10/25/66	
22c. PHYSICIAN'S NAME (Type) Sherman S. Robinson, M.D.		22d. ADDRESS Hahn ProfCent., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/26/1966	23c. NAME OF CEMETERY OR CREMATORY Lady of The Fields	23d. LOCATION (City or Town) (County) (State) Gambrills Md. A. A.
24. FUNERAL DIRECTOR Raymond C. Fink		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE OCT 27 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13653

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PINES ON THE SEVERN</u> 02.1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL General Hosp.</u>		d. STREET ADDRESS <u>ARNOLD, MD.</u>	
3. NAME OF DECEASED (Type or print) <u>TRAGESER</u> <u>ALBERT</u> <u>J.</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHANIST</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK TRAGESER</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>W. ALBERT TRAGESER #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure, acute</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 9, 1966</u> to <u>Oct 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 9, 1966</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R. M. Smith</u>		22b. DATE <u>Oct 9, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-12-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HSBURY</u>		23d. LOCATION (City, town, or county) (State) <u>ARNOLD MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyons</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1938

STATE OF OHIO

1938

IN SENATE

January 23, 1938

REPORT

OF THE

COMMISSIONER

OF THE

DEPARTMENT

OF

AGRICULTURE

AND

FORESTRY

AND

MINERAL INDUSTRY

AND

WATER RESOURCES

AND

WILDLIFE

AND

FAUNA

AND

FLORA

13653

CERTIFICATE OF DEATH

13654

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box #66		d. STREET ADDRESS Box #66	
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Tucker		4. DATE OF DEATH October 12 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 16, 1888
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months X Days X IF UNDER 24 HRS. Hours X Min. X	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ran A.A. County Home		10b. KIND OF BUSINESS OR INDUSTRY County	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Louise Virginia Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-54-1665	
17. INFORMANT McLvin E. Tucker		Address Chesverly, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease (c) Years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Had been disabled for years because of numerous strokes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident or injury	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 10, 1966 to Oct 12, 1966 , that (I) (we) last saw the deceased alive on 10/12/66 , and that death occurred at 7:45 P M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Wirth, M.D.		22b. DATE SIGNED 10/12/66	
22c. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D.		22d. ADDRESS Lothian, Maryland 20820	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Oct	23c. NAME OF CEMETERY OR CREMATORY QUAKER	23d. LOCATION (City or Town) (County) (State) Galesville, Md
24. FUNERAL DIRECTOR Hardesty, Funeral Home, Galesville, Md		25a. REC'D BY REGISTRAR OCT 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1990

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13654

CERTIFICATE OF DEATH

13655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Karol Middle Frank Last WAJBEL		4. DATE OF DEATH Month October Day 6 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1882
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months 1 Days 24 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scaler (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter Wajbel		14. MOTHER'S MAIDEN NAME Veronica (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215 05 7214	
17. INFORMANT Mr. Amiel B. Wajbel (son)		Address Cape St. Claire Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Bronchogenic carcinoma (primary) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, Left hemiparesis, Uremia due to undetermined cause			INTERVAL BETWEEN ONSET AND DEATH 4 weeks - years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from Sep 10, 19 66 , to Oct. 6 , 19 66 , that (I) (we) saw the deceased alive on Oct. 6, 19 66 , and that death occurred at _____ M, from causes and on the date stated above.	
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED Oct. 6, 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS SouthRivMedCent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 8/66	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn, RFD, Maryland	
24. FUNERAL DIRECTOR R. V. Singleton		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 7 1966	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13655 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13650

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wicomico</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandy MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>George Waters</u>				4. DATE OF DEATH <u>10-4-1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1888</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Tom Waters</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BURNS - TOTAL - 3rd.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9:10</u> <u>10/4</u> <u>1966</u> P.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home Fire</u>		20f. (City or town) <u>ADAC</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Howard</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Howard</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-7-1966</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>				22d. LOCATION (City, town, or country) <u>Letham MD</u> (State)			
23. FUNERAL DIRECTOR <u>William Reese</u>				24a. REC'D BY REGISTRAR <u>Charles Judge</u> 24b. REGISTRAR'S SIGNATURE <u>10-4-66</u>			

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James Tolst. 3rd

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13656

Item 3 Film 0381

10/17/66

13657

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital				d. STREET ADDRESS Box 406 Route 2			
3. NAME OF DECEASED (Type or print) First Middle Last GERALD A. Watkins WALKINS				4. DATE OF DEATH Month Day Year 10 10 19 66			
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/6/45	
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction				10b. KIND OF BUSINESS OR INDUSTRY Construction			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Watkins				14. MOTHER'S MAIDEN NAME Sally Mae Holland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes				16. SOCIAL SECURITY NO. Verdella White Rt 1 B. 406 S. P. CO. Md			
17. INFORMANT Verdella White				Address Rt 1 B. 406 S. P. CO. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound of Chest DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 981X DUE TO DUE TO DUE TO							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during apparent burglary			
20c. TIME OF INJURY Hour e.m. 12:00		Month, Day, Year 10/10 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Severna Park		(County) Anne Arundel		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/10/66							
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.				EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) 10/14/66				22b. DATE THEREOF 10/14/66			
22c. NAME OF CEMETERY OR CREMATORY Serpentine Cemetery				22d. LOCATION (City, town, or country) (State) Annapolis, Md.			
23. FUNERAL DIRECTOR J.B. Johnson				24a. REC'D BY REGISTRAR OCT 11 1966			
24b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sunset Beach</i>				c. LENGTH OF STAY IN 1b <i>14 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>				d. STREET ADDRESS <i>16 Granada Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Jacob</i> Last <i>Webster</i>						4. DATE OF DEATH Month <i>October</i> Day <i>23</i> Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 14, 1886</i>		9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months <i>10</i> Days <i>23</i> Hours <i>14</i> Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waleman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Tugboat Captain</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Deale Island, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Jacob Webster</i>						14. MOTHER'S MAIDEN NAME <i>Jones</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>W-1-1149 216-10-908</i>		17. INFORMANT <i>Edward Webster</i>				Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> 4281 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>none</i> (c) <i>none</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>October 1, 1966</i> , to <i>October 23, 1966</i> , that (I) (we) last saw the deceased alive on <i>October 21, 1966</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>R.M. McLaughlin</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10/23/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>						22d. ADDRESS <i>3708 Mountain Road, Pasadena, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>10/25/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>			23d. LOCATION (City, town or county) (State) <i>Balto Co Md</i>			
24. FUNERAL DIRECTOR <i>McCully FH 237 Patapsco Ave 21225</i>						25a. REC'D BY REGISTRAR DATE <i>OCT 24 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13658

CERTIFICATE OF DEATH

13659

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 42 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. #1 Box 368	
3. NAME OF DECEASED (Type or print) First Lee Middle Vann Last Wehr		4. DATE OF DEATH Month 10 Day 10 Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 6, 1930
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airline Decorator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Illinois, Rockford USA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Anton Vanoski		14. MOTHER'S MAIDEN NAME Ann Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 332 24 0491	
17. INFORMANT Mr. Harry Wehr 3rd Arundel Beach Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Cirrhosis of the Liver DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1965 to 10/10 , 19 66 , that (I) (we) last saw the deceased alive on 10/10 , 19 66 , and that death occurred at 11:50 P M, from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 10/11/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		22d. ADDRESS 59 Franklin St., Annapolis, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/66	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Woodlawn Maryland	
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC.		25a. REC'D BY REGISTRAR OCT 14 1966	
ADDRESS BALTIMORE, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WATERLOO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hosp't.</u>		d. STREET ADDRESS <u>R.D. #2 Box 167</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET Lucille West</u>		4. DATE OF DEATH Month Day Year <u>10 9 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MARSHALL MICH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MELVIN MCKEE</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE MARTIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>HENRY C. West.</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-9</u> , 19 <u>66</u> , to <u>10-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-9</u> , 19 <u>66</u> and that death occurred at <u>2 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	23d. LOCATION (City or Town) (County) (State) <u>WATERLOO N.Y.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>		25a. REC'D BY REGISTRAR <u>Annapolis, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		DATE <u>OCT 11 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13660

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13661

1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA. A.A. GENERAL Hospt.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>322 ADAMS ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SYLVIA WHEELER</u>				4. DATE OF DEATH <u>OCT 3 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 17, 1903</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>LEONARD WHEELER #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis generalized</u> 4500 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>10/3/66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF Cem.</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR SONS ANNAPOLIS MD.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>OCT 10 1966</u>			

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323 HONOR ST

JULY 19 1963

LEONARD WHITE

autobus group

Richard

Richard

Group for 61111 Good Street San Francisco CA 94102
Group for 61111 Good Street San Francisco CA 94102

13661

CERTIFICATE OF DEATH

13663

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 38 Parole St.,	
3. NAME OF DECEASED (Type or print) First Benjamin Middle (none) Last WILLIAMS		4. DATE OF DEATH Month October Day 24 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1885
9. AGE (In years, last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Williams		14. MOTHER'S MAIDEN NAME Mary Abrams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Bessie C. Johnson		Address 24 Parole St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH about 1 hr weeks years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paralytic Ileus			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from 19 66 , to Oct. 24 , 19 66 that (I) (physician) last saw the deceased alive on Oct. 24 , 19 66 , and that death occurred at 12:45 PM from causes and on the date stated above.			
22a. SIGNATURE Faye Watson Allen		22b. DATE SIGNED 10-27-66	
22c. PHYSICIAN'S NAME (Type) Faye Watson Allen		22d. ADDRESS 62 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-66	
23c. NAME OF CEMETERY OR CREMATORY Forbes		23d. LOCATION (City or Town) (County) (State) Best Gate Rd.	
24. FUNERAL DIRECTOR William Reese #11111111		25a. REC'D BY REGISTRAR OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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